Schema Therapy Advanced Techniques: Working with Rigid, Avoidant, Grandiose and Impulsive Clients

Ruth Holt and Rita Younan

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ISST guidelines for online certification

You have agreed

- *to be observed when completing dyadic exercises as in live workshops*
- *to arrive on time and do not leave early (10 minute grace is acceptable)*
- *to not engage in other activities that are not related to the training during workshop*
- *to be willing to make up for lost learning should there be a technological problem*

Breaks

Morning Tea
11 (Aust)

Lunch
1 (Aust)

So give yourself the gift of focused attention

Outline of Workshop Day 1

Module 1: The Schema Therapy Model

Schema Therapy Etiology of PDs

Basic Theory of ST, specifically Mode Model

Special Issues with connecting with this population

Module 2: ST Mode model, evidence base and starting therapy

Cluster B & C Mode Maps

Evidence Base

Goals of Mode Work

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Outline of Workshop Day 2

Module 3: Empathic Confrontation and Limit Setting

Core elements in EC

Self reflective practice and self-care in Schema Therapy

Module 4: Advanced Experiential Techniques

Healthy Adult Mode- Imagery Rescripting; Arntz Protocol

Historical Role Play

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Outline of Workshop Day 3

Module 5: Working with Child Modes – problematic eating, addiction and sexual acting out

Child Modes

Impulsivity

Module 6: Steps in Child Mode work and Advanced Imagery with Child Modes

Steps in working with Child Modes

Advanced Imagery work

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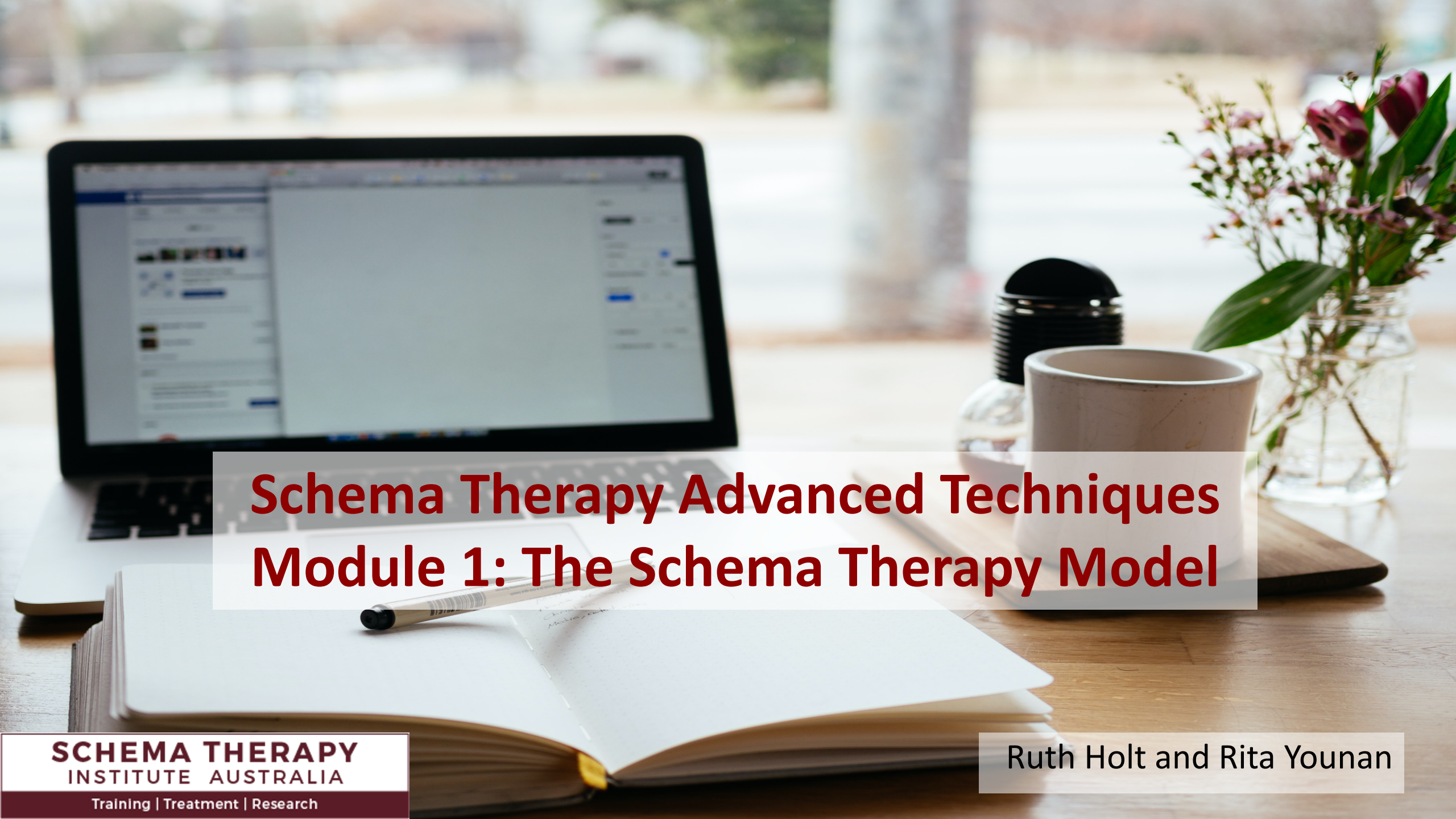

Schema Therapy Advanced Techniques
Module 1: The Schema Therapy Model

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About Us, About You & Workshop Brainstorm

- About Rita
- About Ruth
- About You?
- Needs for workshop?
- What makes this population difficult to work with?

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How do these issues present in the room?

Avoidance	Rigidity	Grandiosity	Impulsivity

Schema Therapy provides a model of psychopathology that explains etiology & Clinical Presentation & on which Psychotherapeutic treatment can be built for both Patient & Therapist

Core Emotional Needs

- The need for a secure, safe, loving, and reliable bond with one or more caregivers
- The need to be supported over the course of growing up, in moving from helplessness and dependence to a sense of competence, autonomy
- The need to find appropriate expression for emotions and needs in a way that leads to needs being met
- The need to learn how to flexibly manage and control one’s emotional and behavioural reactions
- The need to express oneself spontaneously, playfully and creatively

EMS's develop in response to:

1. Toxic frustration of needs
2. Traumatization, victimization, mistreatment
3. Over-indulgence
4. Selective internalization or identification

- Negative Childhood/Adolescent experiences
- "Repisodes" – the tone .theme of early environment
- Temperament or neurobiology play a role

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Interaction with Temperament

Table 2 A proposed taxonomy of higher-order and lower-order personality traits in childhood and adolescence

Higher-order traits	Extraversion/ Positive Emotionality	Neuroticism/ Negative Emotionality	Conscientiousness/ Constraint	Agreeableness
Lower-order traits	Social Inhibition/ Shyness Sociability Dominance Energy/ Activity Level	Anxious Distress Irritable Distress	Attention Inhibitory Control Achievement Motivation	Antagonism Prosocial tendencies

Antisocial features

Avoidant and Obsessive features

Shiner and Caspi, 2003

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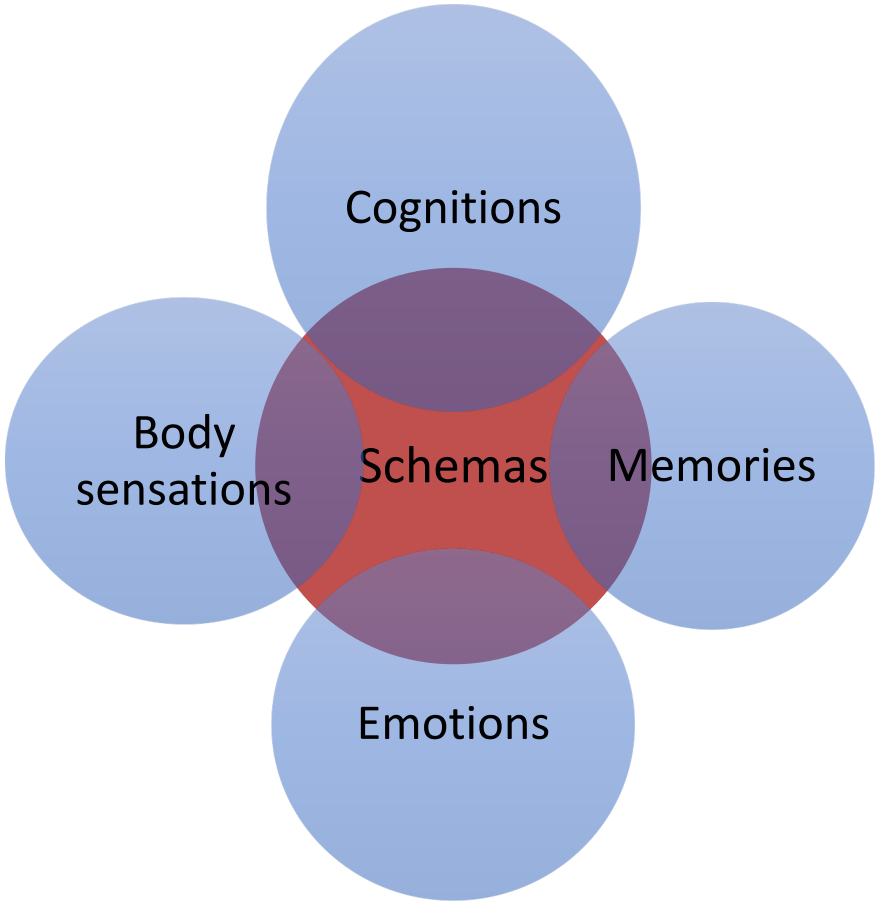
Schemas & Developmental Needs

- Early Maladaptive Schemas develop when specific core childhood needs are not met (coupled with temperament)
- A broad, pervasive theme regarding oneself and others which are self-perpetuating



18 Early Maladaptive Schemas in 5 Domains

I. DISCONNECTION-REJECTION
- Mistrust & Abuse
- Defectiveness
- Emotional Deprivation
- Social Isolation
- Abandonment

II. IMPAIRED AUTONOMY & PERFORMANCE
- Failure
- Vulnerability
- Enmeshment
- Dependence

III. IMPAIRED LIMITS
- Entitlement
- Insufficient Self Control

IV. OTHER-DIRECTEDNESS
- Self-Sacrifice
- Subjugation
- Approval/recognition seeking

V. OVER-VIGILANCE & INHIBITION
- Emotional Inhibition
- Negativity
- Unrelenting standards/hypercritical
- Punitiveness

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Domain I

I. DISCONNECTION-REJECTION

- **Mistrust & Abuse**
- **Defectiveness**
- **Emotional Deprivation**
- **Social Isolation**
- **Abandonment**

Domain II

II. IMPAIRED AUTONOMY & PERFORMANCE

- **Failure**
- **Vulnerability**
- **Enmeshment**
- **Dependence**

Domain III

III. IMPAIRED LIMITS

- **Entitlement**
- **Insufficient Self Control**

Domain IV

IV. OTHER-DIRECTEDNESS

- **Self-Sacrifice**
- **Subjugation**
- **Approval/recognition seeking**

Domain V

V. OVER-VIGILANCE & INHIBITION

- **Emotional Inhibition**
- **Negativity**
- **Unrelenting standards/hypercritical**
- **Punitiveness**

7 minute schemas

Ruth Holt and Rita Younan

Certified Advanced

Schema Therapists, Supervisors/Trainers

Conditional Vs Unconditional Schemas

- Abandonment/Instability
- Mistrust/Abuse
- Emotional Deprivation
- Defectiveness
- Social Isolation
- Dependence/Incompetence
- Vulnerability to harm
- Enmeshment
- Failure
- Negativity/Pessimism
- Entitlement/Grandiosity
- Insufficient Control
- Punishment

- Subjugation
- Self-Sacrifice
- Approval-Seeking/Recognition Seeking
- Emotional Inhibition
- Unrelenting Standards/Hypercriticalness

Coping styles - Surrender

Schema surrender (Freeze – submit to schema)

“Alex is a nineteen-year-old college student. When you meet him, he does not look you in the eye. He keeps his head down. When he speaks, you can barely hear him. He blushes and stammers, puts himself down in front of other people, and is constantly apologizing. He always takes the blame for things that go wrong, even if they are not really his fault.” Reinventing your life p41

Coping styles -Avoid

Schema avoidance (Flight – run from schema activation)

“Brandon has never had a close relationship. He spends most of his spare time yakking with his buddies at the neighbourhood bar. He has been an alcoholic his entire adult life. When we asked him how he felt about himself, he denied having feelings of low self-esteem or shame."

RyL p43

Coping styles - Overcompensation

Schema overcompensation (Fight –act opposite)

“Max is a thirty-two-year-old stockbroker. On the surface he is self-confident and assured. In fact, he is a snob. He has an air of superiority. He is very critical of others while rarely acknowledging any faults in himself. Max chose a very passive, self-sacrificing wife who worshiped him. Through the years, he had become so verbally abusive and selfish that she had finally insisted that either they start therapy or she would leave.”

RyL p44

Common coping responses

- Aggression
- Hostility
- Dominance
- Overcompensation
- Recognition seeking
- Stimulation seeking
- Impulsivity
- Substance abuse

- Compliance
- Dependence
- Excessive self-reliance
- Compulsivity
- Inhibition
- Psychological withdrawal
- Social Isolation
- Avoidance

The Mode Model:

Schema Modes

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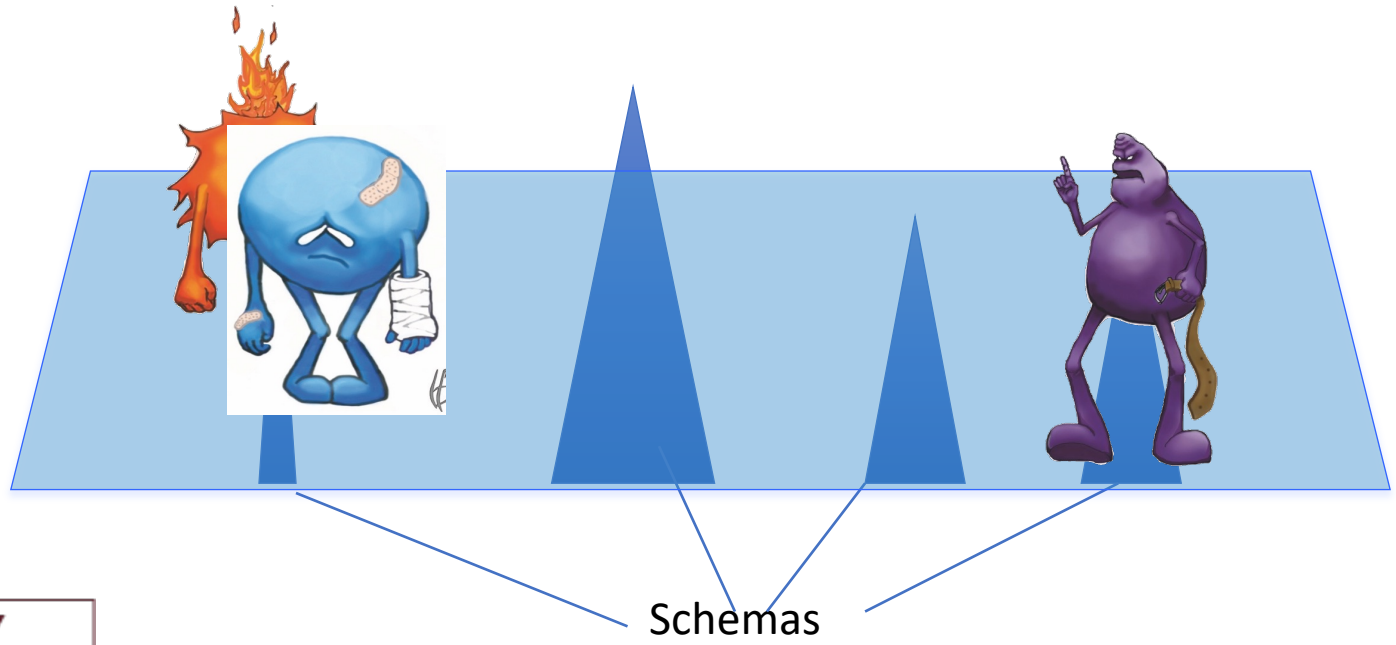
Schema Modes are…

- Moment to moment **fluctuating emotional states** that dominate the person's thoughts, feelings, and behaviors at a given moment.
- Modes can shift rapidly **'mode flipping'**
- Could refer to modes as **'the different parts of us'.**

Modes and Schemas

- When schemas are activated perception, interpretation, mood and behaviour are impacted – Modes occur



Schemas & Modes:

- Impair the capacity to form secure attachments & healthy relationships
- Impair self-esteem and emotional stability
- Distort cognitive processing in situations relevant to the specific unmet needs
- Depending upon severity and frequency can lead to impaired functioning, interpersonal problems, personality disorders or features

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Modes

- Developed working with personality disordered clients
- Transient and serve different functions

Moods

higher functioning
Continuous awareness
Sometime maladaptive
Flexible

Dissociated parts of self

lower functioning
Mode 'takes over'
Maladaptive and
Rigid

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Young et al., 2003, Lobbestael, van Vreeswijk & Arntz, 2007

4 Main Clusters

Child modes

- Innate responses to unmet needs

Critic/Parent modes

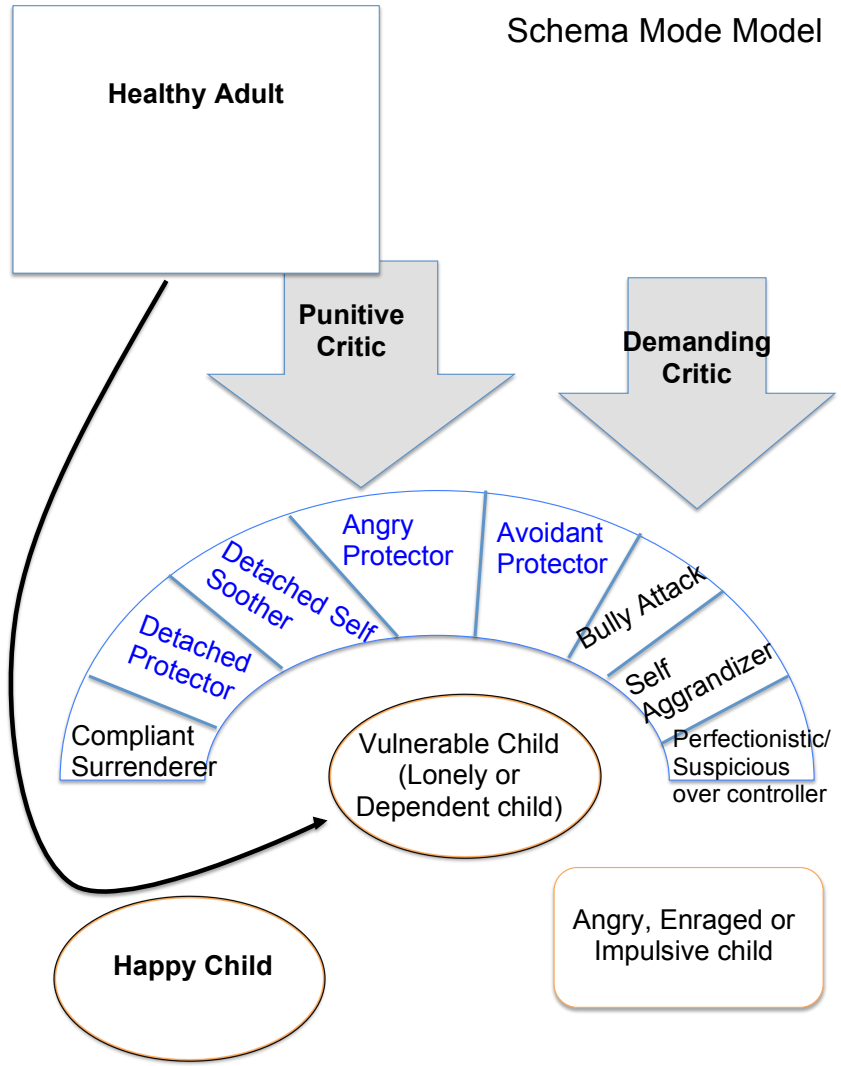
- Selective internalization

Coping modes (Flight, Fight, Freeze)

- Over-used survival responses to trauma or unmet core needs

Healthy Adult/Happy child

- Under-developed



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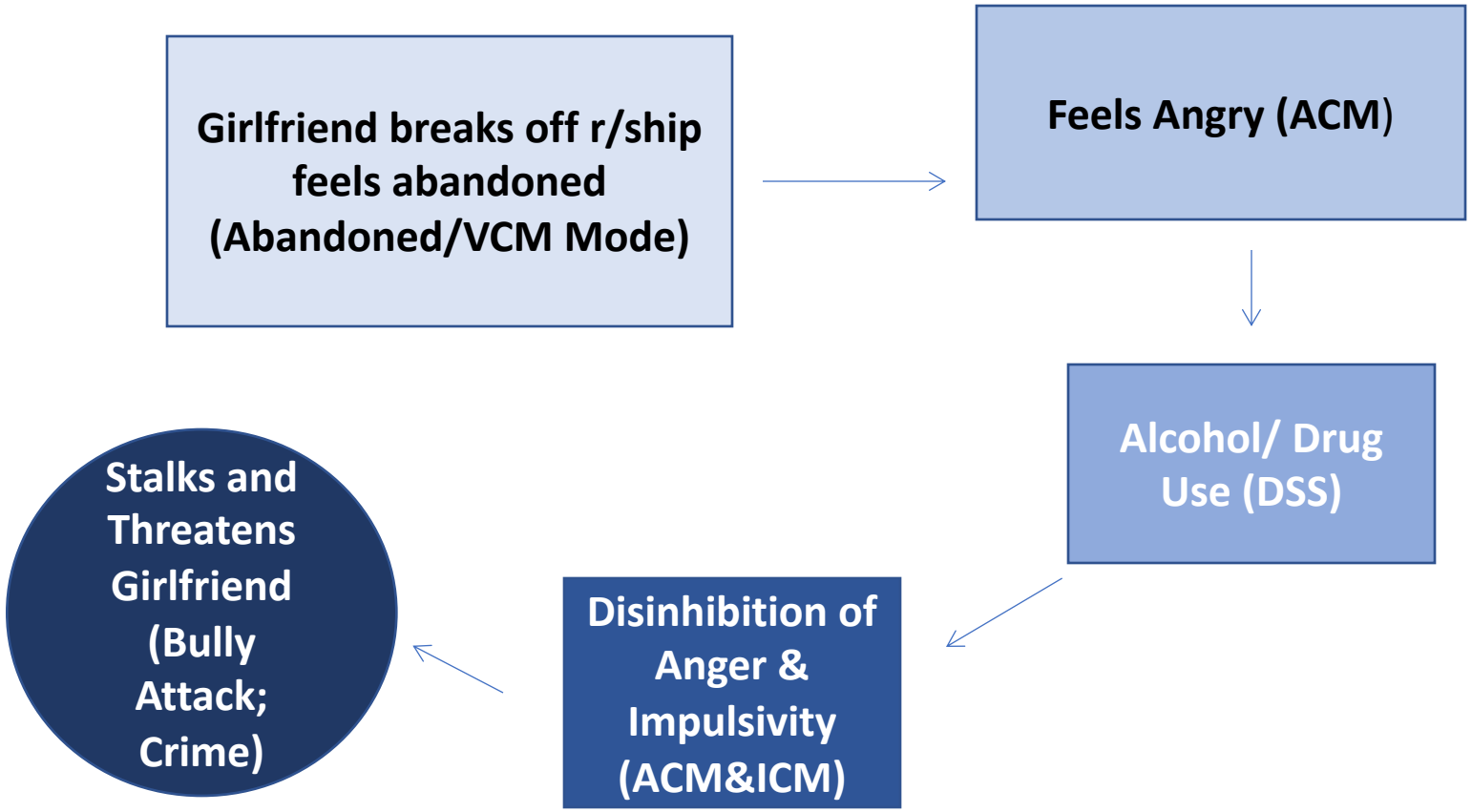
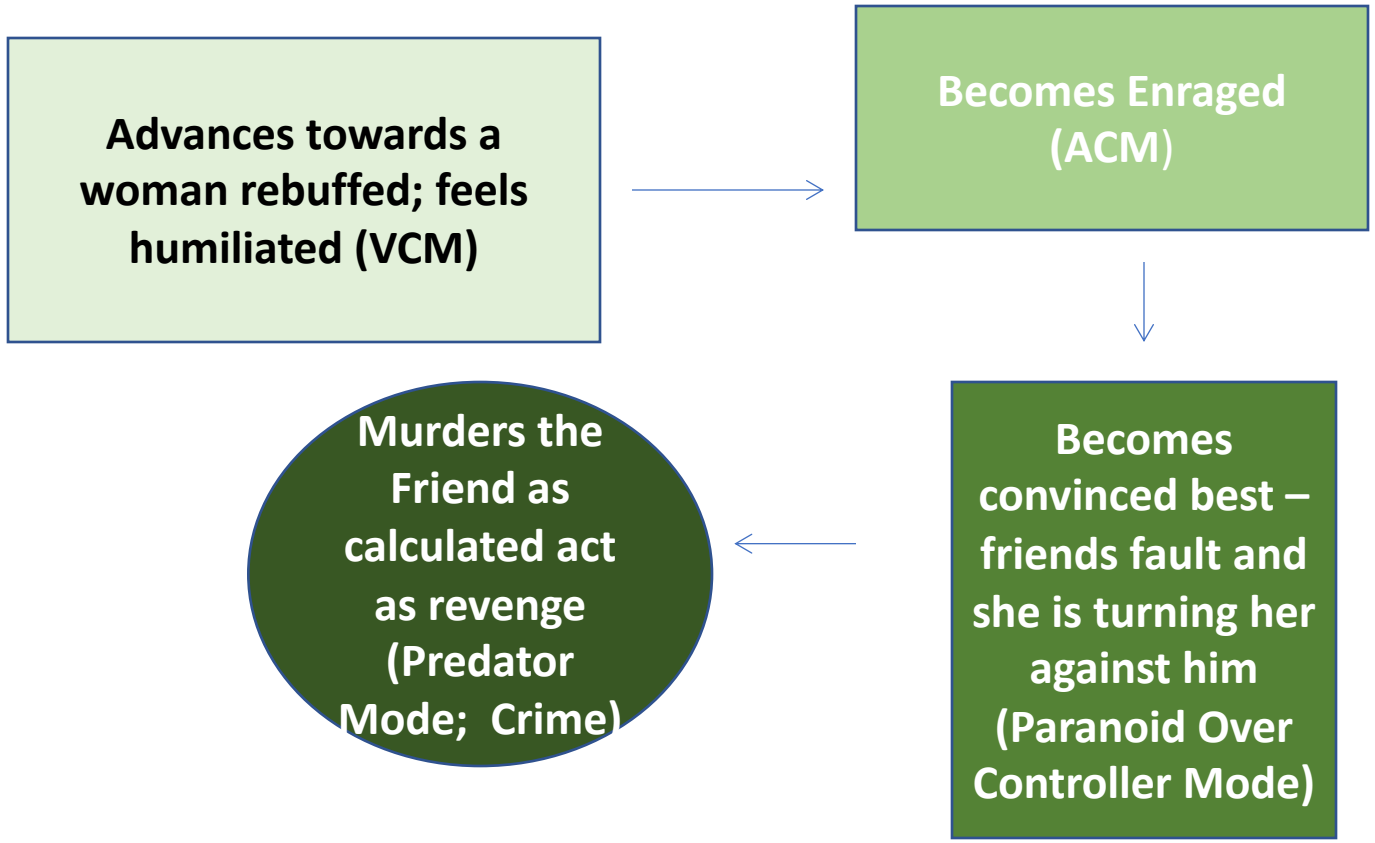
Schema Modes and Offending Behaviour (Bernstein et al., 2014)



Schema Modes and Offending Behaviour (Bernstein et al., 2014)



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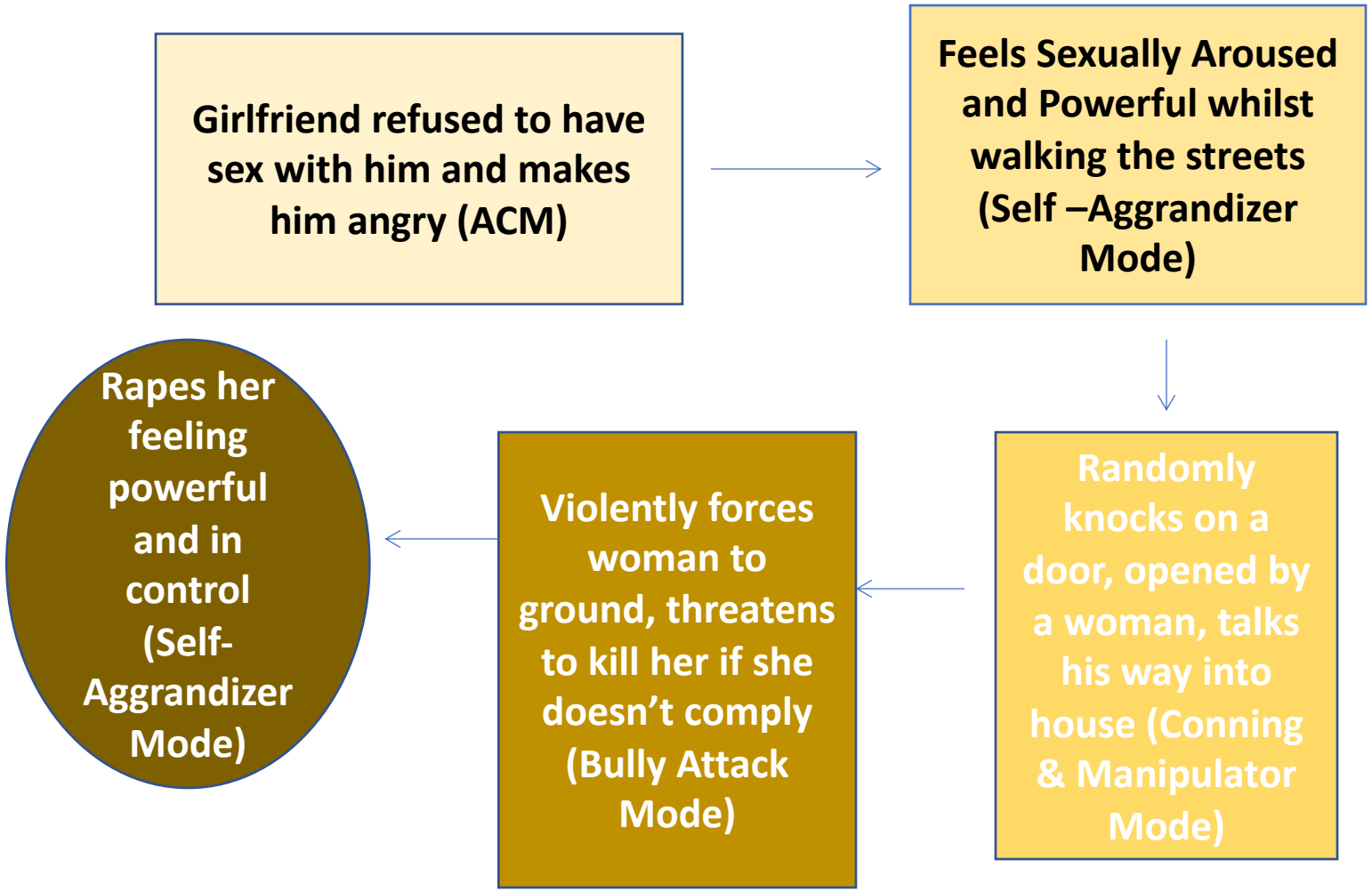
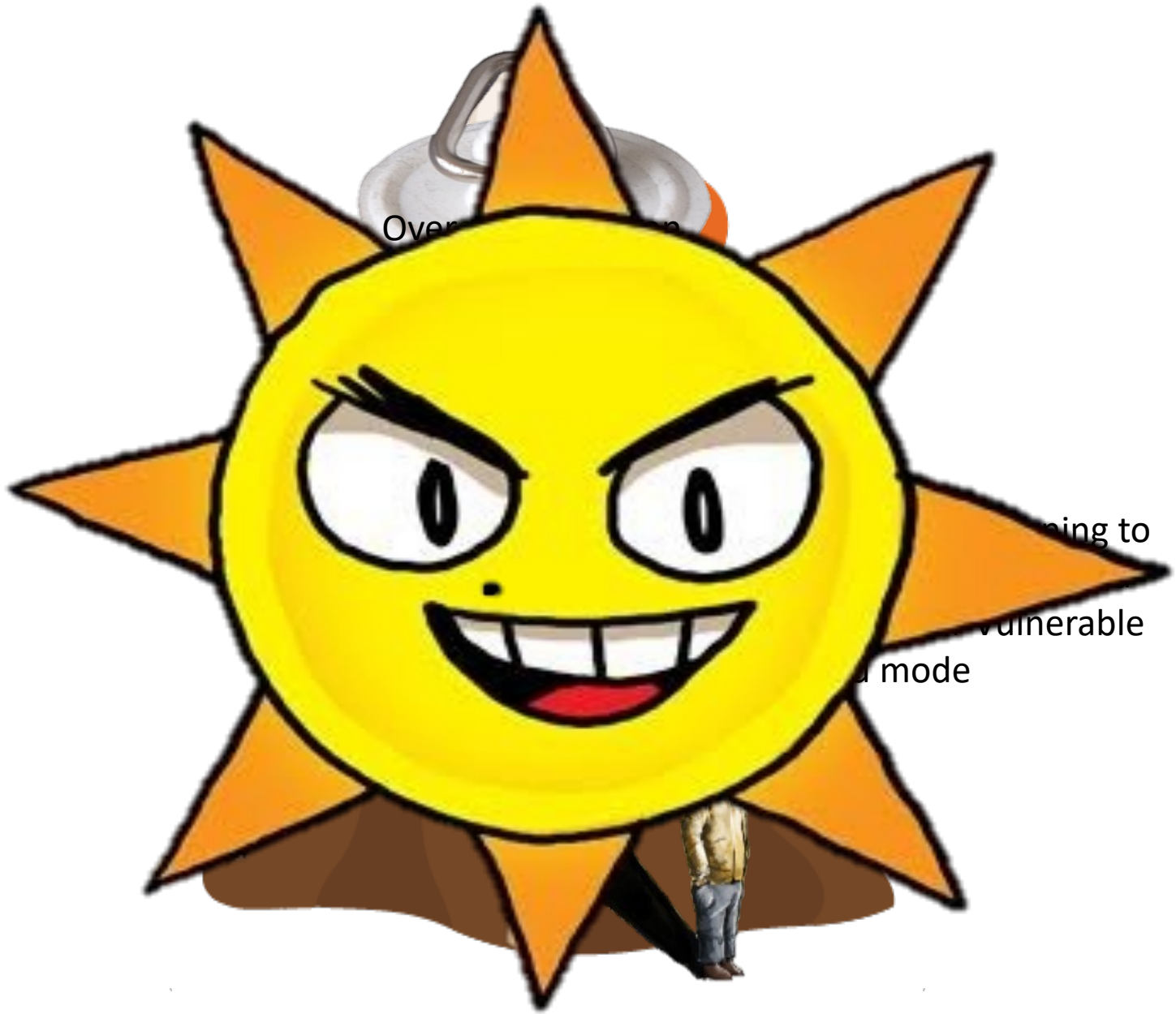


Overcompensation in Schema Therapy

- People endeavour to be as different as possible from the children they were when acquiring the schema
- If they felt worthless as a child they aim to be perfect; if they were abused they will abuse; If controlled they will control or reject all forms of influence
- Faced with the Schema they "***Counterattack***"- on the surface they appear confident & assured or critical and controlling, but underneath they feel the press of the Schema threatening to erupt.
- This can be seen as healthy way of coping with the Schema *but* "***Overshoots the Mark"***

Young, Klosko & Weishaar, 2003


Over
ing to
ulnerable
mode

Overcompensation Continued

People usually develop ways of coping through overcompensation to cope with feelings of loneliness, helplessness, inferiority or threat.

Overcompensation Modes

Self Aggrandiser

Narcissistic arrogance (present as superior and contemptuous). Feels superior, special, or powerful.

Perfectionistic O/C

Obsessive Control uses order, repetition, or ritual, insists on telling others what to do and taking control.

Overcompensation Modes

Predator

Cold-blooded focus on eliminating a threat, rival, obstacle, or enemy in a cold, ruthless, and calculating manner.

Paranoid O/C

Attempts attempts to protect oneself by locating and uncovering a hidden (perceived) threat.

Overcompensation Modes

Conman/Manipulator

Cheating and Conning (manipulate others to enforce own interests). This is typical of people who grew up in very insecure environments.

Bully Attack

Aggression (physical violence and/or verbal intimidation). Aggressive overcompensation is typical of people who have experienced severe violence and threat in their past.

Assessing Coping Modes in the "here and now"

Questions to consider

1. What are you noticing in the here and now? Is there a mode present that is causing a therapeutic impasse/disruption?
2. What is patient's emotional state? (e.g., no emotion, tense, angry, sad or fear) the modes primary emotion?
3. What might have triggered mode? Therapist late to session, questioned truth about something?
4. What might patient be thinking (you betrayed me? I'm the boss here not you?)
5. What is patients coping style? Does this create distance, a power struggle, or submissive?
6. How do you feel when patient is in this mode (anxious, irritable, resentful, detached, giving in to patient) what mode might you be in as a result of patient's mode?

Assessing evolution of Coping Modes with Imagery

If I took away your coping mode what would it be like?

- In your relationship
- At your work

Practice Assessment Imagery

Practice with one of your own patients or Steve

If I took away your coping mode what would it be like

- In your relationship
- At your work

Special Issues with connecting with this population

Narcissistic PD and Grandiosity

- “I don’t have a problem” – avoiding the problem
- “I don’t have a problem” – unwilling patient
- Therapist defectiveness/failure schemas

Special Issues with connecting with this population

Antisocial PD and Impulsive clients

- “I don’t have a problem” – mandated treatment
- Therapist critical and avoidant modes activated

Special Issues with connecting with this population

Obsessive Compulsive and Avoidant PD

- Rigidity
- Chronic hypervigilance
- “I don’t have a problem” – low insight
- Therapist compliant to control and avoidance agenda

Interview with Wendy Behary about connecting with these clients

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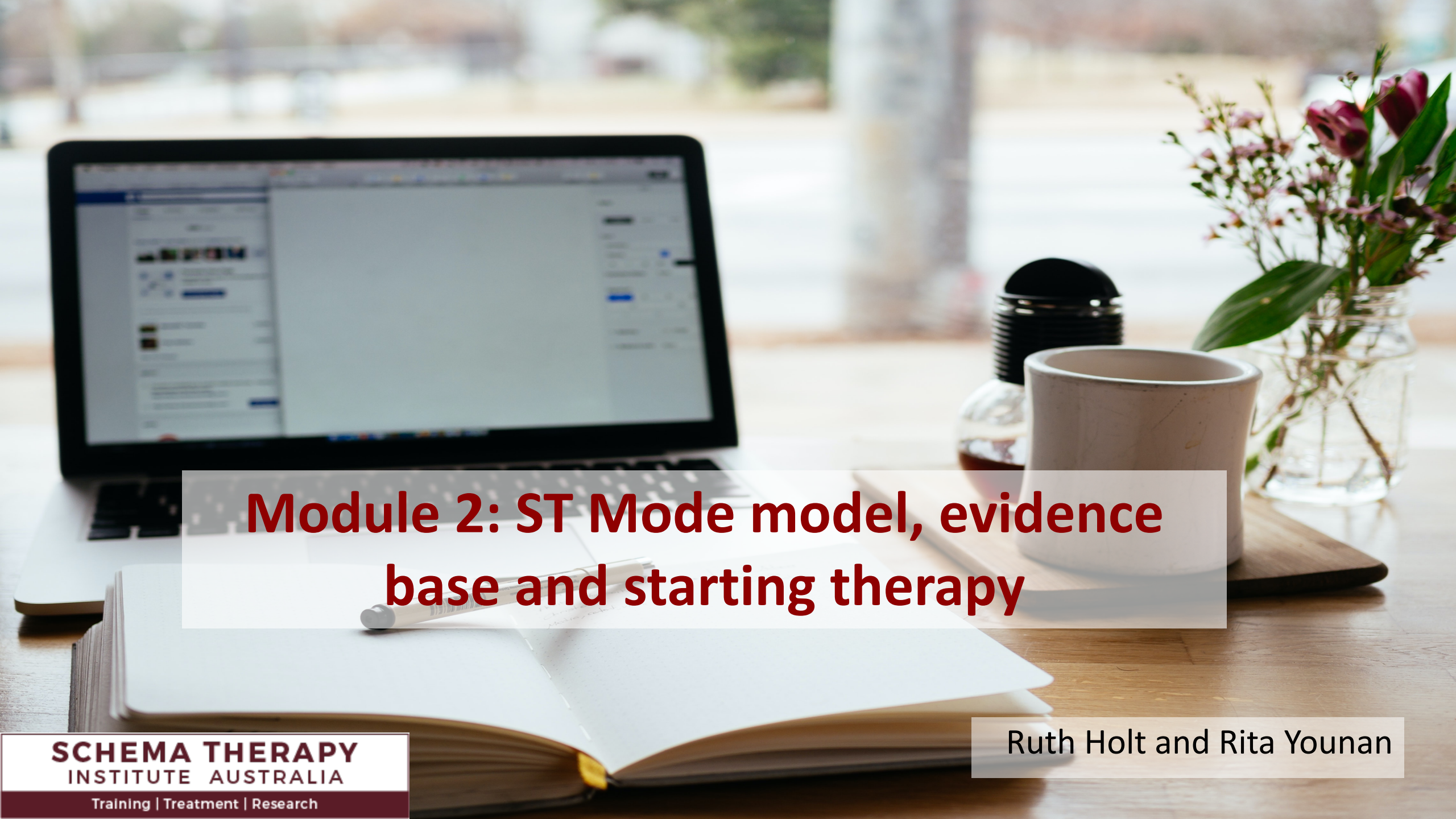

Module 2: ST Mode model, evidence base and starting therapy

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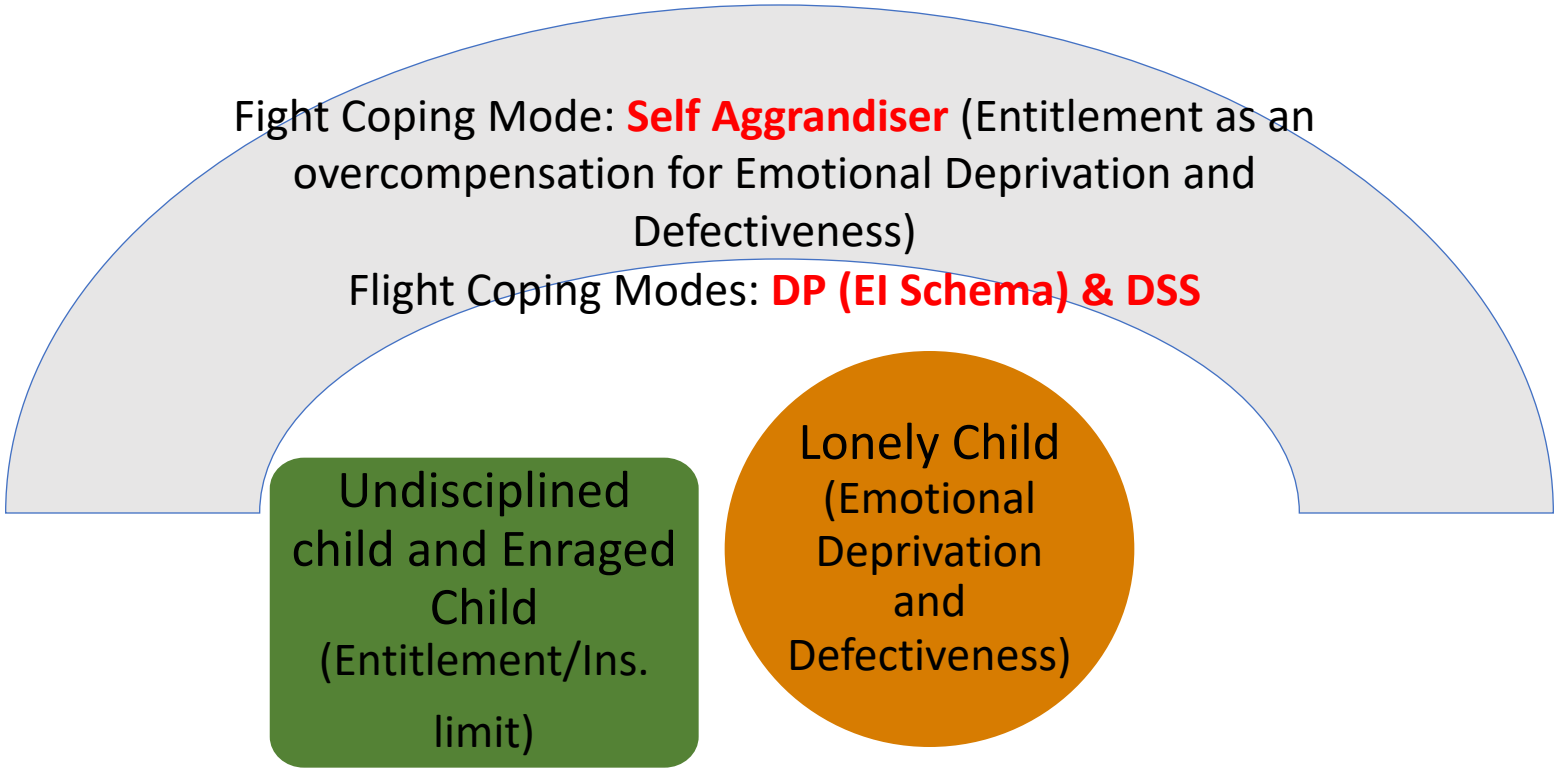
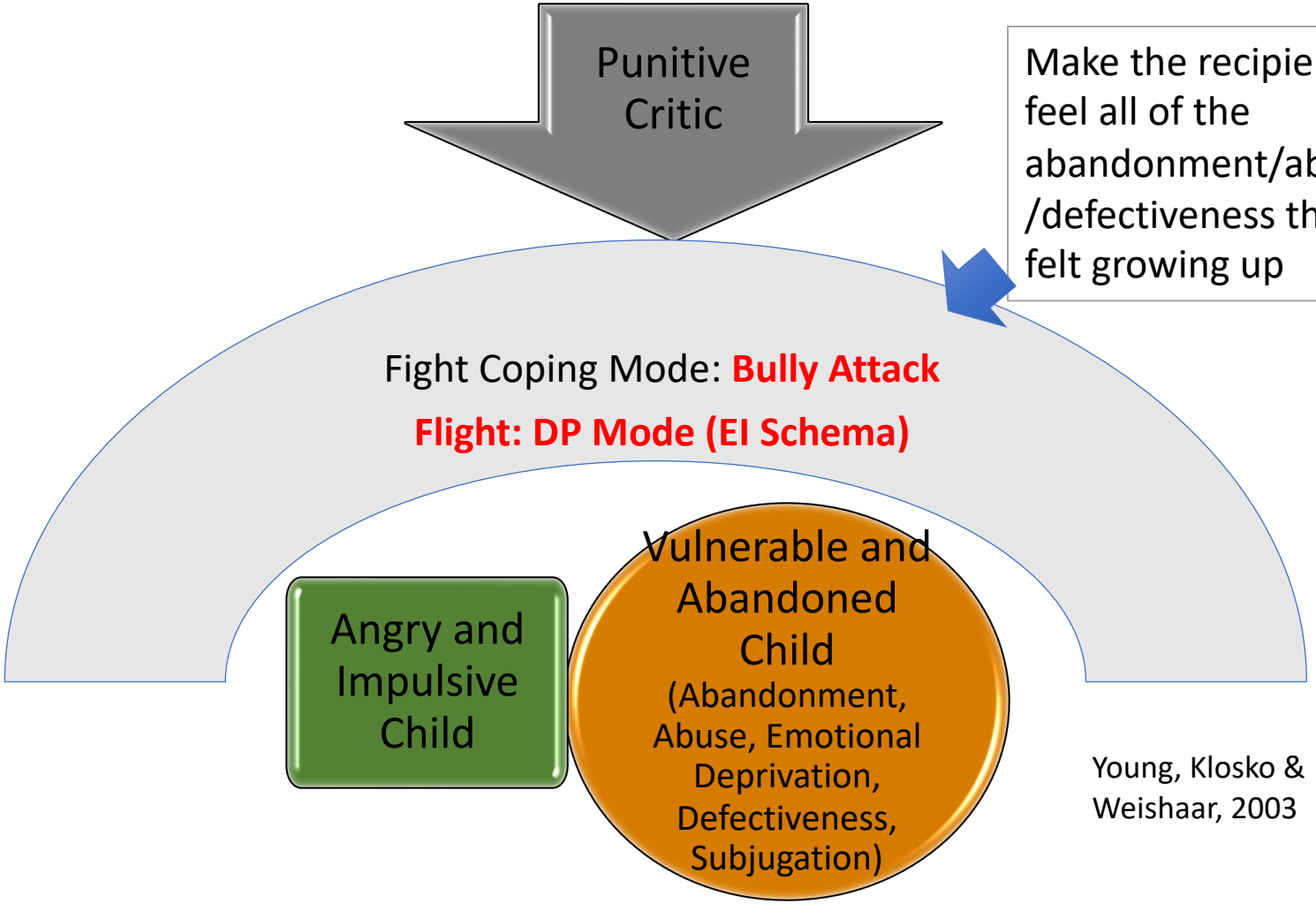
Mode Maps for Cluster B PD’s

Narcissistic Personality Disorder



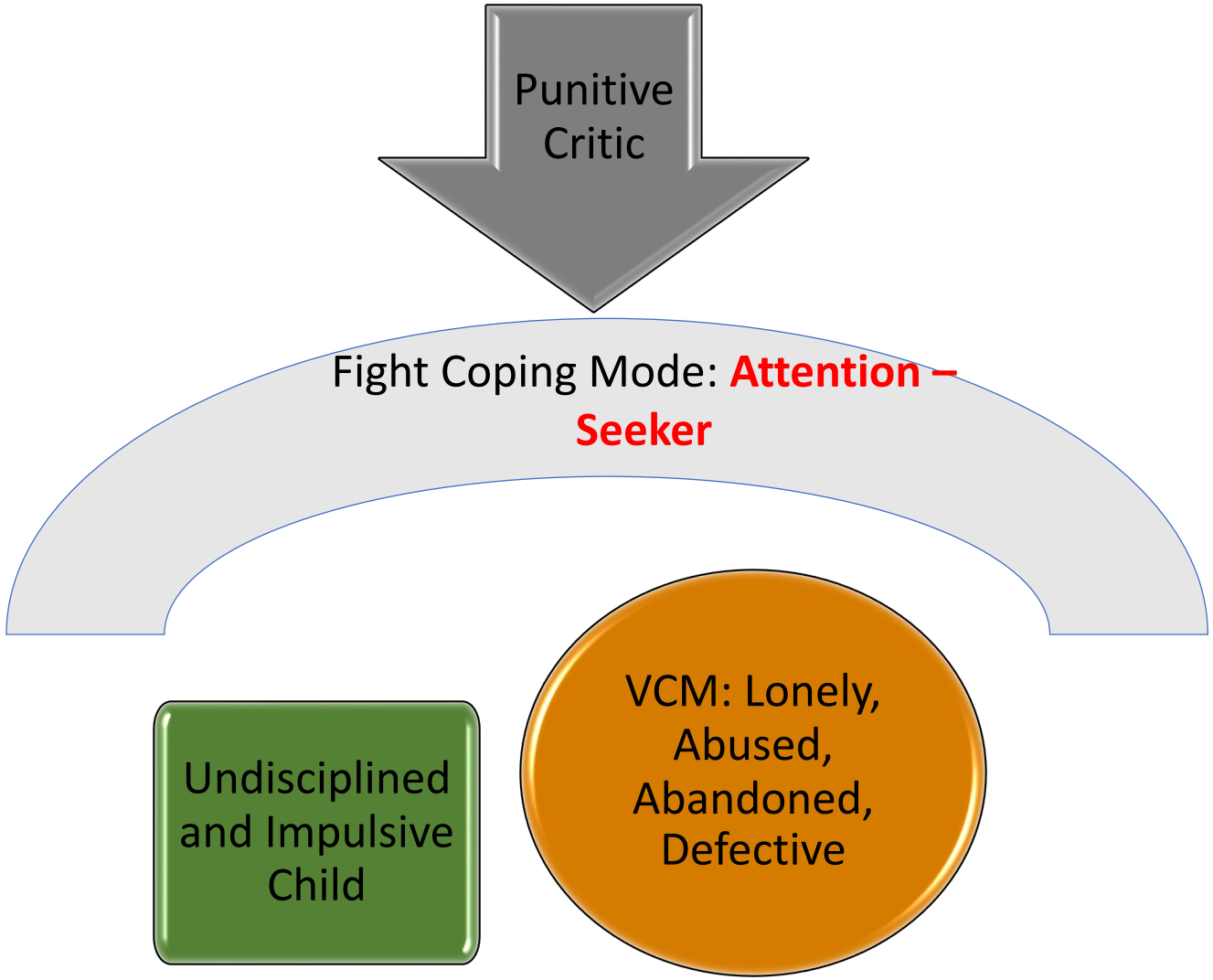
Bamelis et al., 2011

Borderline Personality Disorder



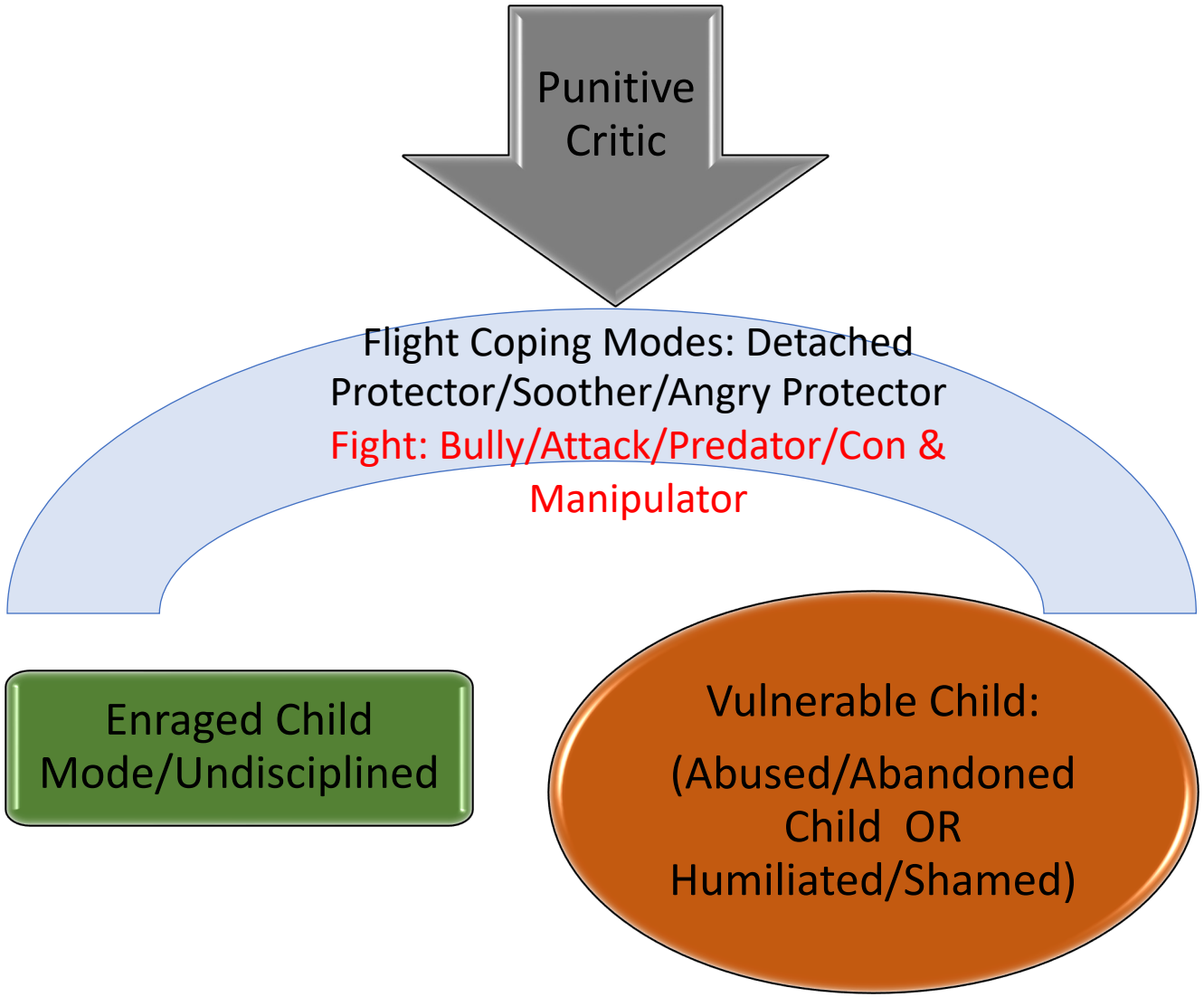
Young, Klosko & Weishaar, 2003

Histrionic Personality Disorder



Arntz, 2012 and Bamelis et al., 2011

Antisocial Personality Disorder



Arntz, 2012 and Bamelis et al., 2011

Interview with David Bernstein about connecting with these clients

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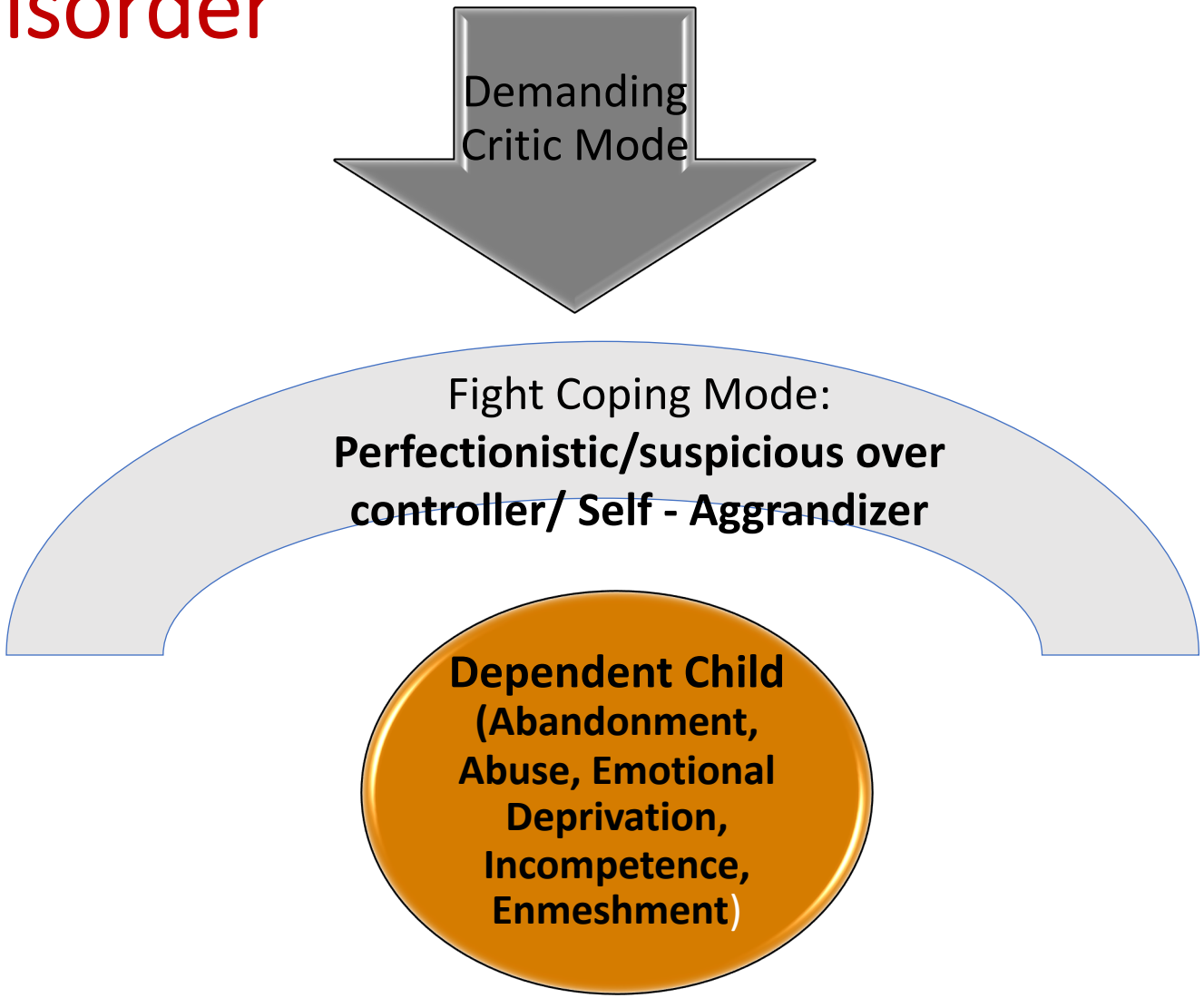
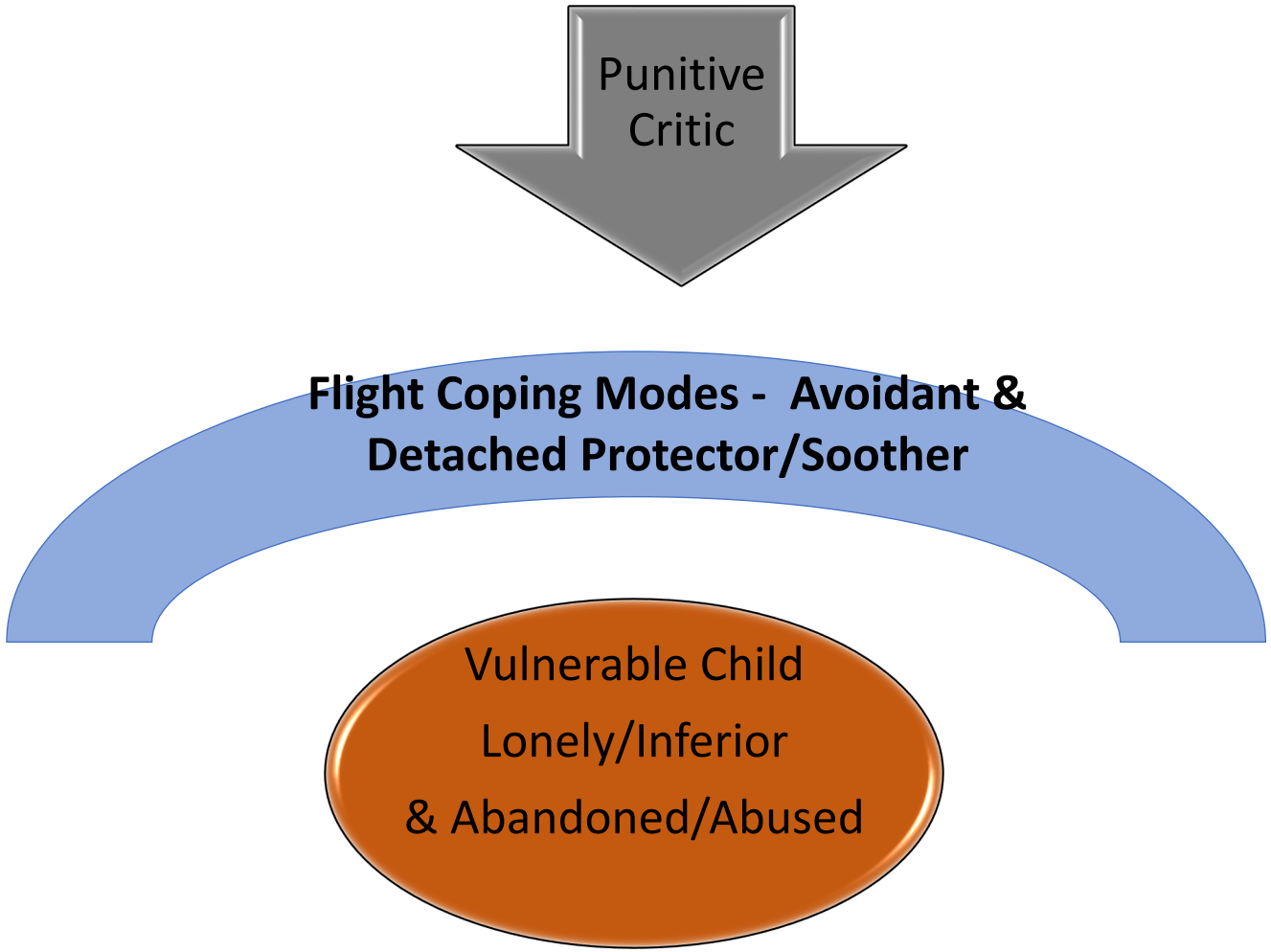
Mode Maps for Cluster C PD’s

Obsessive- Compulsive Personality Disorder



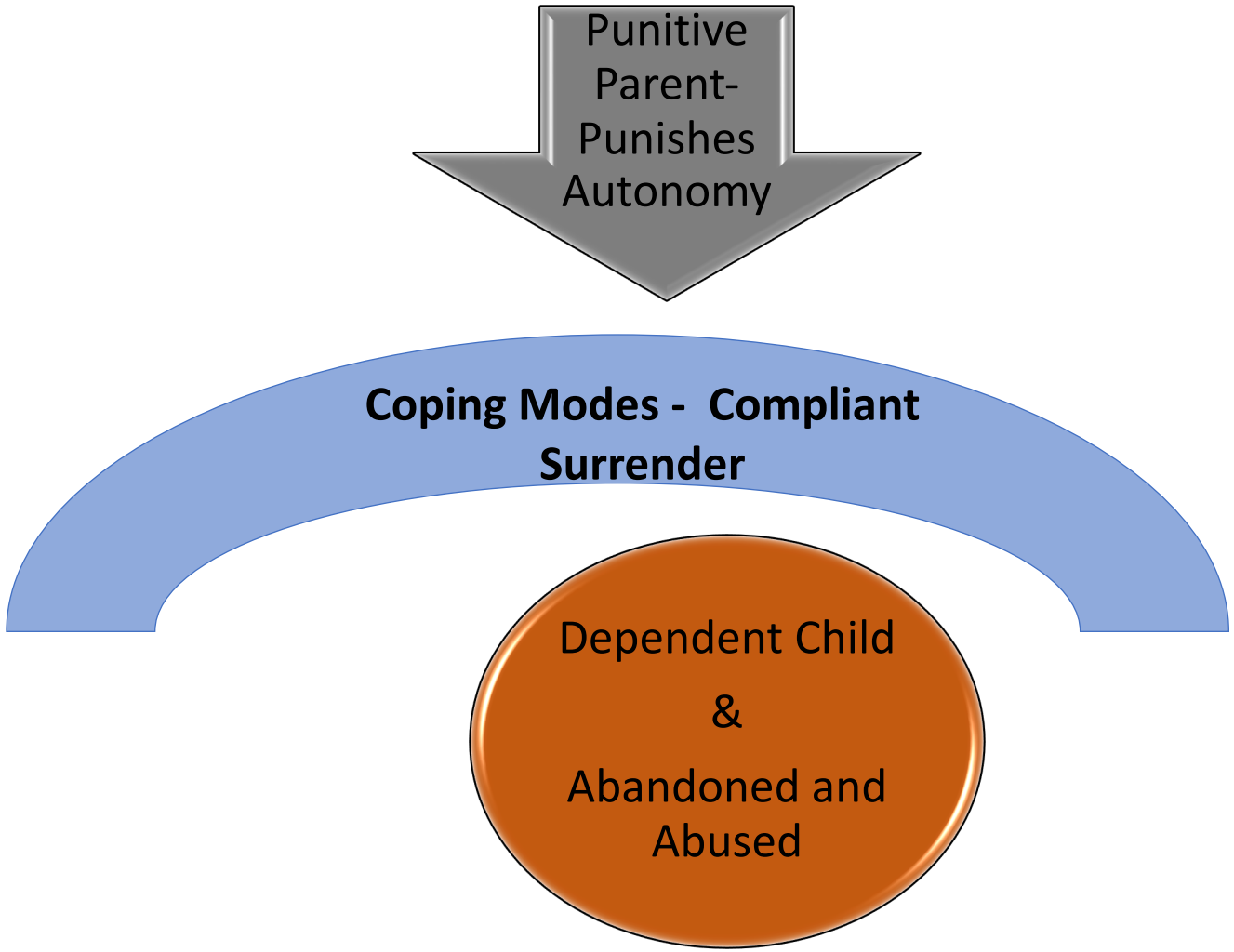
Arntz, 2012 and Bamelis et al., 2011, Bachrach & Arntz 2021

Avoidant Personality Disorder



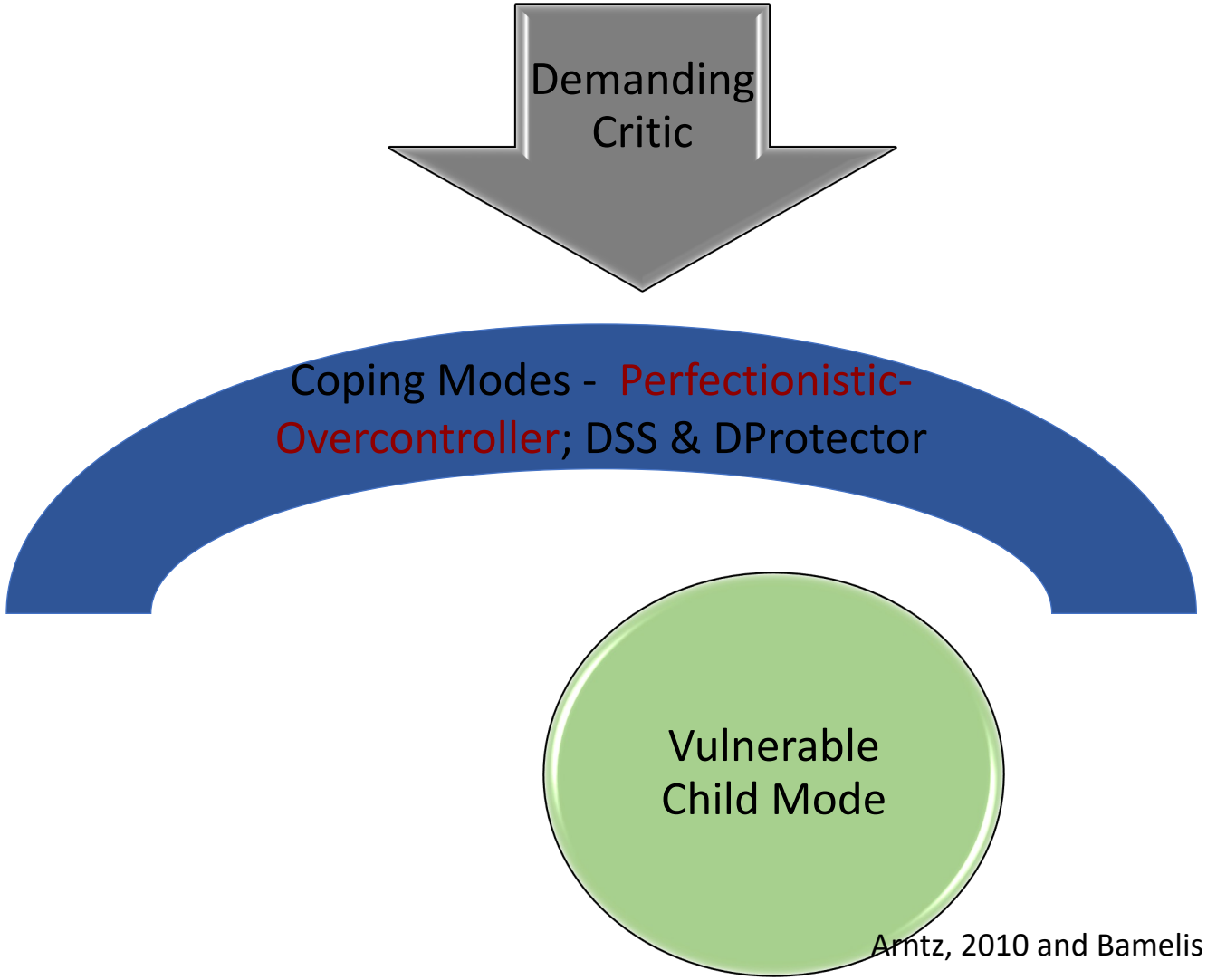
Arntz, 2012 and Bamelis et al., 2011, Bachrach & Arntz 2021

Dependent Personality Disorder



Arntz, 2010 and Bamelis et al., 2008, Bachrach & Arntz, 2021

Healthy Psychotherapists



Arntz, 2010 and Bamelis et al., 2008

Evidence Base

Selected Research - Cluster B and C

Reference	Study Design	Therapy	Patients	Outcomes
Forensic setting				
Bernstein et al, 2023	ST compared to TAU at eight high-security forensic hospitals in the Netherlands	3 years of individual therapy, 50 minute sessions twice per week, reduced to once per week after patients attained leave	N= 103 Anti-social, narcissistic, borderline, or paranoid PDs, or Cluster B PDNOS	All patients improved on the outcome measures. ST was superior to TAU on both primary outcomes – rehabilitation (i.e. attaining supervised and unsupervised leave) and PD symptoms
Group and Individual research				
Arntz et al., 2022	RCT – St (individual and group formats v TAU – 36%=DBT as well as Psychodynamic/SCBT and others	1 group + 1 indiv session each week, yr 2 1st 6 months every 2nd week then tapered	BPD N=495	combined individual and group schema therapy was significantly more effective than optimal treatment as usual and predominantly group schema therapy in reducing BPD severity.
Outpatient – Group Therapy				
Arntz & Bachrach, 2020	Large RCT underway	30 X 90 minute weekly group sessions + 4 booster sessions (including 300 min individual work)		
Individual Schema Therapy				
Bamelis et al, 2014	RCT- ST vs Classification oriented therapy & TAU	3 years of Individual therapy; Median 50 Sx's	Cluster C (51% Avoidant in ST & Similar in TAU), Paranoid, histrionic, & NPD N= 323	-↑ recovery in ST group than other 2; ST group ↑ in Social functioning and Dx at Flw up.

Overview of the Phases of Treatment for Cluster C

- Year One: 40 Sessions
- Sessions 1-6: introduction, case conceptualisation
- Sessions 7-25: focus on childhood
- Sessions 25-40: focus on present & behavioural change
- Year Two: 10 Booster Sessions

(Arntz, 2012)

Bernstein et al., Retrospective study & Prospective Study in Forensic Cluster BPD patients

- Examined relationship between schema modes, psychopathy and institutional violence
- Schema modes were assessed retrospectively in patient crimes
- Sample of 95 hospitalised cluster B personality disordered offenders
- Results of this analysis showed that criminal behaviour was often preceded by schema modes related to feelings of vulnerability, abandonment, loneliness and stages of intoxication (e.g., child modes). Criminal behaviour itself was characterised by states of impulsivity, anger, and the use of overcompensatory strategies involving threats, intimidation and aggression.

Evidence Base: Forensic Patients

- Bernstein, D., Nijman, H., Karos, K., Keulen-de Vos, Vogel, V., & Lucker, T. (2012). Schema Therapy for Forensic Patients with Personality Disorders: Design and Preliminary Findings of a Multicenter Randomized Clinical Trial in the Netherlands. *International Journal of Forensic Health, 11, 312-324*.

- Study was a three-year randomised clinical trial and three –year follow up comparing ST to TAU found in these settings
- Male forensic patients with PDs, antisocial, BPD, NPD and Paranoid PD (102 in total over 7 sites)
- 50% of the sample were high on the Psychopathy Checklist – Revised
- Preliminary results: ST patients outperformed TAU
- Preliminary results in this article BUT full results are being published this year

Managing coping modes in Cluster B and C Presentations

THE GOALS OF SCHEMA MODE WORK I

- *Heal the pain of the Vulnerable*, Lonely, Abandoned or Abused child (I.e., Disconnection rejection domain schemas) so that patient is not so easily triggered
- Help the Impulsive Child learn frustration tolerance
- Help the Angry Child learn to experience degrees of anger, and express his anger constructively

THE GOALS OF SCHEMA MODE WORK II

- Lessen the strength of the Coping Modes and Over Compensator Modes, so patient can show his vulnerable side and make emotional connections
- Strengthen the Healthy Adult, so that he can think before s/he acts, and make healthy choices
- Evoke the Happy Child Mode; learn to prioritize fun and spontaneity

Schema Therapy has 4 Intervention types

1. Cognitive Techniques
2. Emotion-focused Techniques
3. Behavioural Pattern Breaking
4. Limited Re-parenting

ST Techniques with Coping Modes: Cognitive Techniques

- Identify and Label the Mode
- Explore the biographical background of the Coping Mode
- Monitor/Track mode in between sessions
- Understand triggers (internal & external) to the Coping Mode in order to create Mx Plans to replace/moderate maladaptive coping (monitoring helps with this)
- Create Pros and Con Lists re: coping Modes

Practice: Identifying and labelling the Mode

In pairs play a client whom you think may have been in an overcompensating mode; as the therapist catch it and name the mode. Don't tell the therapist what mode you are playing

Practice all 5 whether a client of yours or not:

- Bully/Attack
- Paranoid Over-controller
- Conman/Manipulator
- Perfectionistic Overcontroller
- Self Aggrandiser

Common Mistakes

- Therapist too frightened of offending – can call it “your overcompensator”, “policeman”, “the boss”, “scary Bob”, “the ruminator”, “shiny Paula”
- Therapist intimidated and not curious “I’m noticing something happening in the room right now”, “Let’s just pause for a minute … can I get you to notice your body/tone/heart rate?”
- Therapist’s subjugation/self sacrifice schema activated
- Therapist identifies wrong mode and therefore uses wrong intervention

Exploring Mode Worksheet

Bully Attack Mode

When you are in this mode you will harm other people in a controlled and strategic way emotionally, physically, sexually, verbally, or through antisocial or criminal acts. The motivation may be too overcompensate for prevent abuse or humiliation. This can have sadistic properties.

When I am in this mode I:

Say:

Think:

Feel:

Do:

Where did I learn this mode?

How did it help keep me safe in the past?

What needs did it meet? *(*Needs can include; *safety, security, love, acceptance, a senses of identity, power, respect, autonomy, spontaneity, play, a sense of control)*

What has it cost me?

What has been the cost for my partner/friends?

What do I need in place before I would be willing to try a different way of coping?

MY AHOLE SIDE

When you are in this mode you will harm other people in a controlled and strategic way emotionally, physically, sexually, verbally, or through antisocial or criminal acts. The motivation may be to overcompensate for or prevent abuse or humiliation. Can have sadistic properties.

Why I am in this mode I:

Say_____derogatory, abusive, insulting things _____

Do _____yell, I throw things, punch things, __slam things, dogs cop it, _____

Think_____really critical thoughts that are intolerant and demeaning _____

Feel_____vulnerable, depressed, criticized, ashamed, inferior, powerless_____

Where did I learn this mode?

*modelling from dad

*sticking up for myself with bro

*some bullying at school – especially teacher being abusive and intolerant

How did it help keep me safe in the past?

*people couldn't get close

*take control

*make others feel the hurt and pain I feel

What needs did it meet?

*safety, power, protection, sense of control

(Needs can include, safety, security, love, acceptance, a senses of identity, power, respect, autonomy, spontaneity, play, a sense of control)

What has it cost me?

*damages my intimate r/ship with partner especially

What has been the cost for my partner/friends?

*hurts Jane and creates disconnect

What do I need in place before I would be willing to try a different way of coping?

*awareness that I have other choices/the other person is not to blame for what has happened

Monitoring Mode Worksheet

Day	When did Bully Attack show up? What response did BA provide /10	What was the trigger? How bad was it /10	What need was it meeting?	Was there another way of dealing with the situation that would get my need met?

Working Overcompensation – Cognitive techniques

1. **Evaluation on a Visual Analogue Scale**
   Useful for “I’m bad, ugly, a failure”
2. **Multidimensional Evaluation**
   Useful for judging self based on 1 criteria: “I am not worthwhile because I don’t have a job”
3. **Socratic Dialogue**
   Useful for challenging interpretations that are biased by schemas
4. **Two- Dimensional Reproductions of Supposed Connections.**
   Useful for challenging false connections: ”If I don’t have a girlfriend I must be unloveable”
5. **Pie Charts**
   Useful for apportioning “blame” more appropriately, rather than solely the client
6. **Positive Log Book**
   Useful for collecting evidence of the opposite of schemas/critic

ST Techniques with Coping Modes: Experiential Techniques

Mode Dialogues

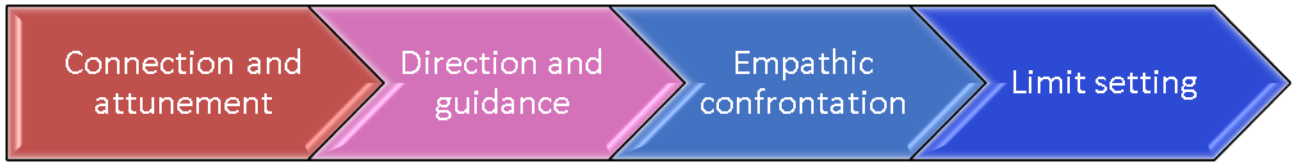
- Explore modes/assessment
- Pros and Cons of modes
  - Therapist Plays VCM to highlight impact of Coping Mode
- Bypass coping modes (also can do this in imagery)

Imagery Rescripting

ST Techniques with Coping Modes: Behavioural Techniques

- Behavioural Experiments re: trying different strategies to coping mode i.e., Mode Mx Plans
- Skills training to assist in changing coping modes i.e., communication skills, emotional awareness, posture awareness
- Awareness and expression of underlying needs; Build Healthy Adult and acknowledge VCM

ST Techniques with Coping Modes: Therapy Relationship



- Limited Reparenting to down-regulate Defence
- Empathic Confrontation & Limit-Setting where needed
- Authentic & Honest Approach (modelling & self-disclosure)
- Encouraged to Express Needs in Session
- *Mixture of meeting attachment needs **and need for limits***

Interview with Wendy Behary about connecting with these clients

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Example Confronting Coping Mode Early On

"Phillip, I understand that you suffer a lot from your social anxiety. However, right now, these fears don't seem to be present, even when we directly address them, you seem distant and dominant.

This is quite a contrast to the anxieties you report. I guess that you are exhibiting some form of overcompensation. Do you happen to be familiar with this term?

...you behave as if the opposite to your problems were true; overcompensation is meant to show others that you are cool and in control of the situation and not anxious at all. What do you think?"

(Arntz & Jacob, 2013)

Telling a story about the Modes

“when John was little, no one was there to protect or care for him. So he had to take care of himself. People mistreated him, so he concluded that people couldn’t be trusted, and that you can only rely on yourself.

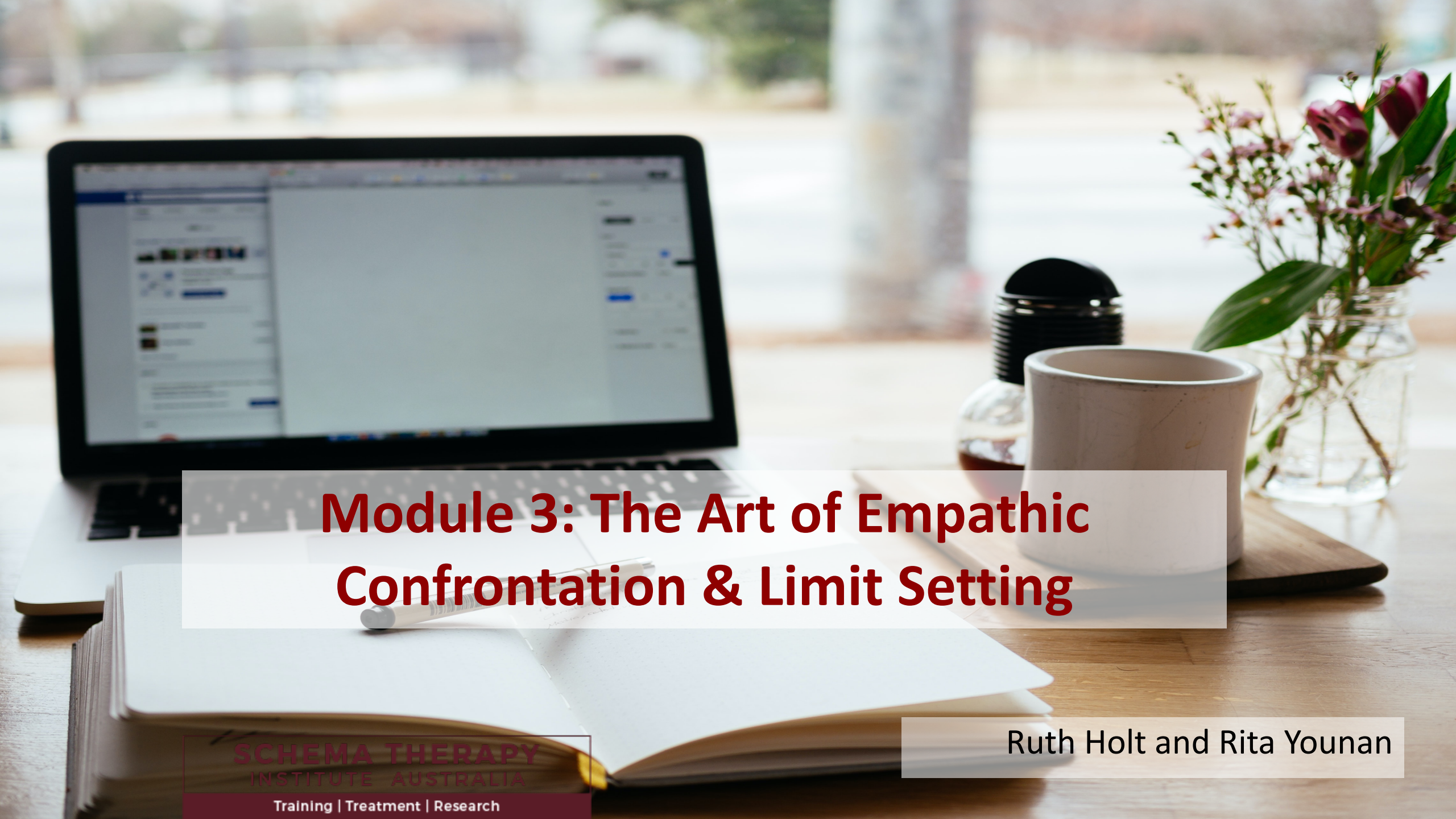
He put up a wall between himself and other people to protect himself. He learned to push away this feelings so that he wouldn’t feel so bad and keep people at a safe distance. This wall part of him got so strong that he forgot all about the Little Child who was hidden away behind it – every little child needs a grown up to protect him. We need to pay attention to the Little Boy inside of you. He needs and deserves that”

(Kersten, 2015)

Practice Cognitive techniques

Choose a rigid, grandiose or avoidant client and practice one of the skills discussed

- Confronting the coping mode
- Telling a story about the coping mode
- Using Wendy Behary's PAUSE technique
- Introducing and working with child photo



Module 3: The Art of Empathic Confrontation & Limit Setting

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Demonstration of different anger presentations

Sensations

Images

Feelings

Thoughts

Guess the Mode

Working with Anger & maintaining Therapeutic Presence

"Therapeutic presence involves therapists being fully in the moment on several concurrently occurring dimensions, including physical, emotional, cognitive, and relational"

Keller & Porges, 2015

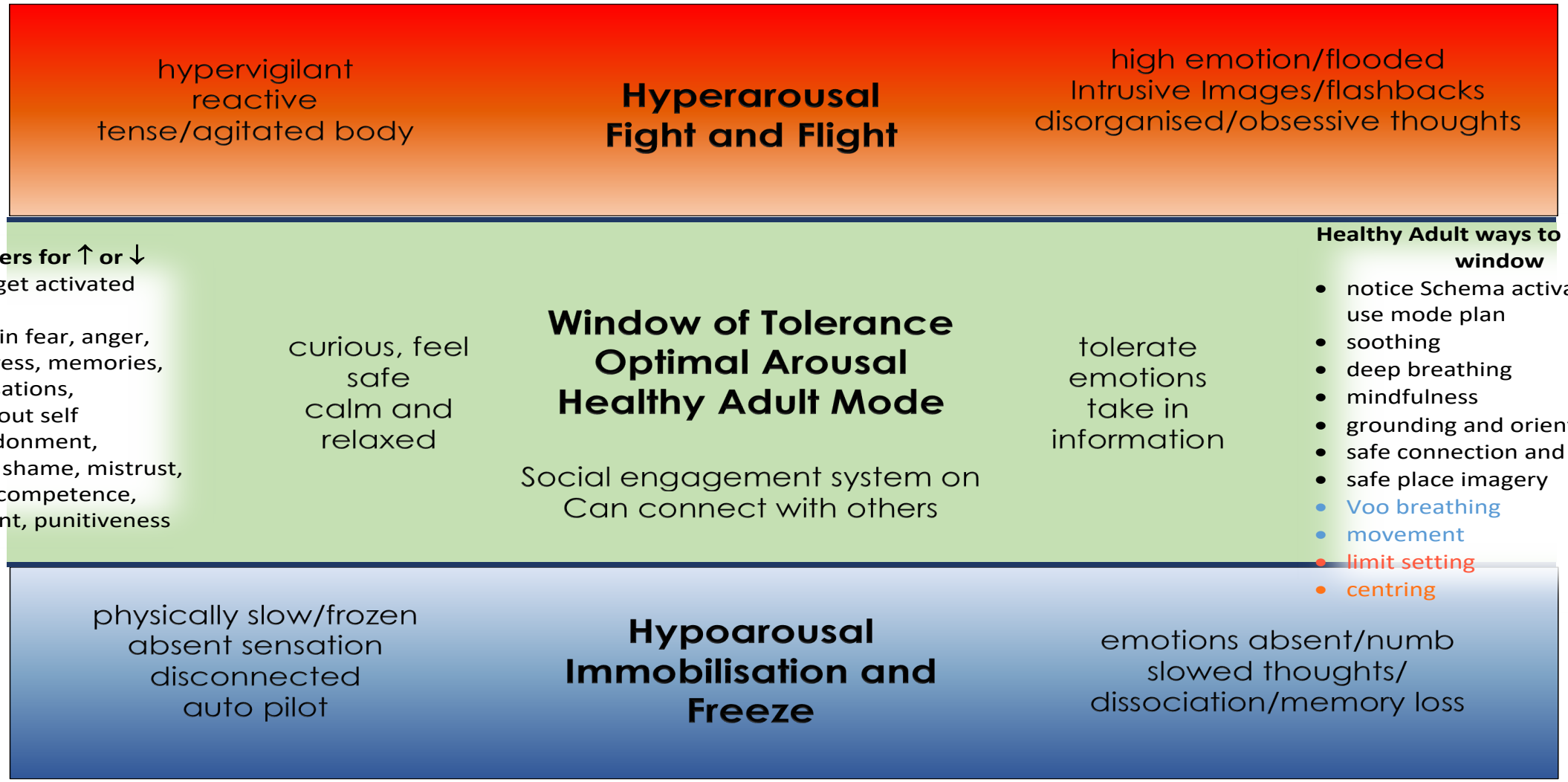
Working with Anger & maintaining Therapeutic Presence

Common Therapeutic Impasses:

- *Therapist misrecognises the patients modes in here and now of therapy relationship?*
- *Therapist may use wrong intervention?*
- *Patient triggers therapist modes?*

Bernstein, 2020

Schema Therapy Window of Tolerance



Ruth Holt and Rita Younan 2020

Reflective Exercise in Pairs Discuss:

- What did you notice about how you feel?
- What sensations did you experience
- What thoughts did you have?
- Notice an impulse/urge?
- Did you find yourself leaning *in* or *leaning back?*
- Could you identify the relevant mode?

Therapist Common Pitfalls Schemas:

- Doesn't enforce limits; avoids confrontation; passive **(Subjugation**)
- Offers patient too much outside time (**Self-Sacrifice**)
- Feels inadequate (**Unrelenting Standards, Failure**)
- Becomes angry, resentful (**Overcompensation**)
- Encourages termination prematurely (**Avoidance**)
- Discourages intense needs & emotions **(Avoidance**)
- Aloof, rigid, impersonal **(Emotional Inhibition)**

Therapist Common Pitfalls Modes:

1) Schema Mode Congruency

- Both therapist and offender in the same mode i.e., Detached Protector; both talking around things, avoiding emotion, analysing or intellectualising

2) Schema Mode Complimentary (One-up and one down)

- For example the offender is in an aggrandizer mode where they are overcompensating and presenting in a superior position, activating the therapists schemas and finds themselves feeling inferior/incompetent etc..

3) Schema Mode Battle

- Almost a power battle with the offender

(Bernstein, 2020)

Therapeutic Relationship: What is Empathic Confrontation?

"Empathic Confrontation is a technique in which patients are very clearly confronted with their interpersonal patterns in the therapeutic relationship…it's empathic because it validates the biographical background of the patients interaction patterns and interprets them as (dysfunctional) a way to care for patients needs" (Arntz & Jacob, 2013)

Empathic Confrontation: What you need?

1. Empathy (The golden nugget)

You need to "… identify with and have a vicarious experience of the feelings, thoughts, or attitudes of the vulnerable part of patient"

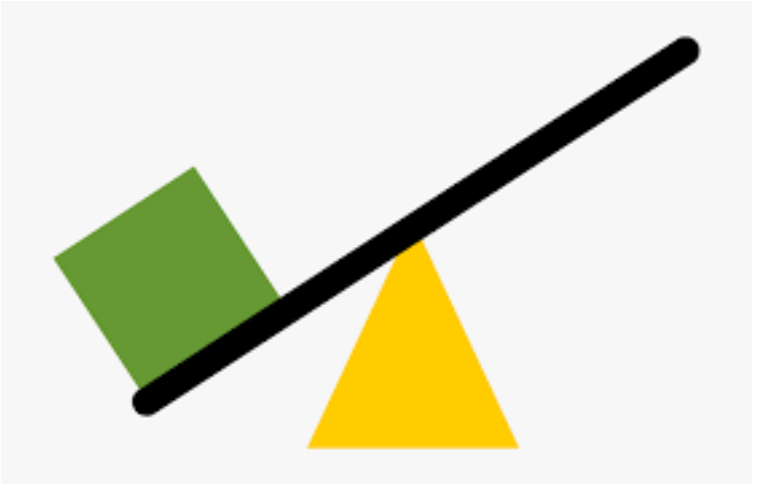
2. Need LEVERAGE!

"John if this doesn't change, your wife will leave you"

"Sally I know you feel like control is keeping you safe, but it's actually pushing your friends away"

"Your bullying is stopping you having the career you want"

Wendy Behary, 2016



When to use Empathic Confrontation

1. Used with therapy interfering behaviours

- Describe what you see:

"I see a side of you"

2. Linking and Labelling Maladaptive Reactions and Self-Defeating Patterns:

"I see a side of you that is a bit like a porcupine – If I get too close I am going to get pricked, I know you are not used to expressing your anger, it has been dangerous to do so, I get it, but if you are angry with me or I did something to upset you, then I would like to know, you deserve that"

When to use Empathic Confrontation

3. To Understand and Hold Accountable:

“you probably don’t realise it but….”

“its really hard for me to empathise with you the way you deserve when you act like this..”

“I have needs too..”

“A part of me wants to connect and help, but another part wants to run right now….I really want to stay with the caring part…”

Therapeutic Relationship: Empathic Confrontation

“I know that you grew up with the message that in order to feel accepted you had to meet certain prescribed standards. You continue to carry forth that theme when you spend a lot of time trying to impress others and dominating conversations. The problem is that it has the quality of being overbearing and boorish after a while, and it leaves your friends and associates feeling like an audience instead of participants in a friendly dialogue.”

Behary & Dieckmann, 2012

Empathic Confrontation: Finding your words

When you talk to me in that tone I feel distant from you, even though you need me to be here for you

I know you don't mean to hurt me, but when you speak to me that way if *feels* like you're trying to hurt me

I get that this is how things worked at home growing up, but in 2020 I'm not sure it is still working

You're paying for you my time, not the right to treat me with disrespect

Empathic Confrontation: Finding your words

Why are you doing this right now?

Why are you pushing me away?

Why are you angry with me?

Young et al., 2003

Why do you think it's important to tell me all of your achievements?

Are we getting stuck in the overcontroller/Self aggrandizer etc again?

Empathic Confrontation: Finding your words

I did something wrong…

We need to look at that

I need you to make some space for us to talk about …

Sit back – “when you are doing that I can’t be there for you”

This needs to be a safe place for both of us

Therapeutic Relationship: Empathic Confrontation

Steps:

1. Reinforce connection with client *e.g., John I care about you….*
2. Name the maladaptive behaviour *When this side of you comes out, the competitive side*
3. Point out that it does NOT get their needs met *I no longer want to help or be around you, I know there is a vulnerable side that needs care*
4. Offer Correction – A behaviour that will get their needs met *I have feelings too, and would like to be respected here*
5. Offer Assistance in learning a new approach *I really want to help you with this, I know it is not your fault but it is your responsibility…*

Farrell and Shaw 2012

Demonstration – Limit setting before Empathic Confrontation with a Bully Attack mode

Practice Empathic Confrontation

Empathically Confront a patient who has come into your session in an Overcompensation mode - how would you confront them?

1. Bully /Attack or S- Aggrandiser
2. Perfectionistic Overcontroller

- Follow the Handouts provided
- Swap roles where possible

Tips for Working with the Overcompensating Coping Modes

- See the coping mode as a defense. A friendly tone can help the person calm down and feel safe, eventually reducing this mode (ventral vagal complex)
- Set limits if becoming bullying or controlling but in a way that the person can hear you are wanting to connect with them rather than criticise them
- Rise above specific self-aggrandizing comments and look at themes in what the person is talking about.
- Avoid debating content where possible.
- Hold in mind the person’s underlying vulnerability that their overcompensating tries to deflect from and cope with.

Don’t do EC at the end of the session when you are really frustrated!

Steve: “There was a time when you did get frustrated at me self-aggrandising for an entire session. But I didn't know I was doing it. I was locked into it and thought it was all fine until you pointed it out at the end. You said maybe I should take a break from therapy but all I heard in my mind was you were turning your back on me as everyone eventually does after I push them too far. I had to basically tread on egg shells for many sessions after that. The trust I had was completely gone for maybe a year after that, it was a long time and I couldn't say anything. In my mind I had to help myself while I could until you cancelled the sessions eventually …

But you said I was making progress and that keeping me focused until one day I realised you were still there"

Tips for Working with the Overcompensating Coping Modes

- Together formulate this mode
- Hone in on and acknowledge and validate examples of assertive communication and self-reflection where possible (i.e., notice their HAM)
- Encourage the individual to identify the advantages and disadvantages of this mode
- Helpful to remain aware that if someone is showing some motivation to reduce their overcompensation, they may initially feel worse/struggle. Consider discussing this with the person, validate their feelings and refer back to likely longer term benefits.

From Steve

“One of the big fears I had initially about schema therapy was being disarmed because I didn't think I would be able to function well if I couldn't use my overcompensator modes like conman. I remember I said to you that you were trying to turn me into a Budhist ... It was easy to just do whatever I wanted. I'm saying I was a better manipulator before therapy because there are no mental blocks or awareness of the negative effects, I just did it automatically … it makes you question yourself as you do it. I used to think I was free but later I realised *I was really a slave to my conman mode.* So I can stop myself … I still do it but I limit it more.”

Working with Overcomp. Modes Outside of Session: *Use of Flashcards to make accountable*

*"Hi Stephen, perhaps you are just checking in, or maybe you are feeling triggered, and have found yourself under the influence of the "Tough Guard" or the "Big Shot". Take a moment, with your eyes closed, see if you can feel your vulnerable feelings. See if you can see- and feel- "little Stephen"? Notice him. What does he need? Does he need some attention, some affection, understanding, holding? Imagine giving "little Stephen" what he needs- even if only for a few minutes. Notice what got you upset, how did you handle it? What needs to be repaired and with whom? Express remorse on how your behaviour impacted them…..it's not your fault you have these modes, but its your responsibility to change them and be accountable….remember it's the **how** you are that gets in your way and becomes unacceptable, not **who** you are….."*

(Behary, 2012)

***Example of am audio flashcard for Steve** to try to manage his Bully/Attack+Conman mode "The Fighter" with his neighbour – getting his dog "wolf" to howl outside their window*

Steve on homework

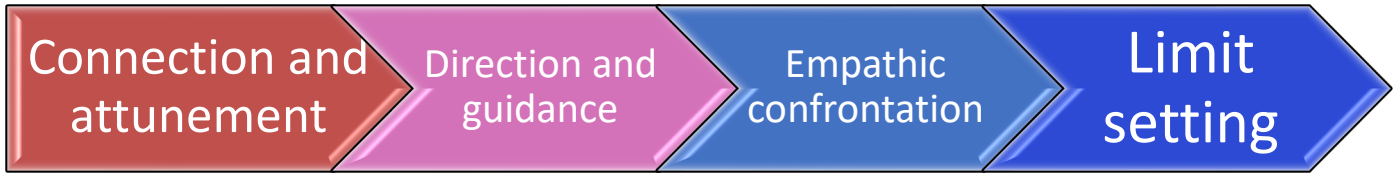
“Learning slowly to understand what each of my main schema modes were and how each of my behaviours were tied to them helped me to understand and overcome some of the worst aspects of them.

That took a long time but without really understanding it then I wouldn't have been able to recognise the modes in real time as events occurred.

The homework was so helpful because of the self-reflection and constantly having to think about past behaviours and schema modes.”

“Limit Setting” – Therapy Interfering Behaviours

“Limited re-parenting” in the therapeutic relationship means that the therapist is warm and cares for the patient. However, the therapist also has to set limits on the patient’s dysfunctional behaviours, just as healthy parents would do for their child (Arntz & Jacob, 2013)



Empathic Confrontation Vs Limit Setting

Limit Setting used when:

- Used when a mode violates rights or crosses boundaries such as safety and respect; delivered in a way that is firm and consequential *but not punitive.*
- Involves saying the word “Stop”, clearly and firmly, and state the rights or needs that make the limit setting necessary.
- Do this in a personal way rather than making reference to formal rules or requirements.

Demonstration – Limit Setting

Limit setting with a Detached Self Soother

Step by step

Practice Limit Setting

Set Limits on a client who

TRY NOT SETTING LIMIT THEN SETTING LIMIT

1. Is in Detached Self Soother and coming to sessions after drinking/using valium

2. Is in Paranoid Overcontroller and saying you are talking about them with your friends

Module 4: Advanced Experiential Techniques

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Working with HAM in Imagery

Main Types Of Rescripting

PRESENT	Safety Images Response to flashbacks (intrusive images) Nightmares
PRESENT TO PAST	Imagery rescripting via affect bridge Phase one Therapist: Imagery rescripting of chosen memory/***Phase two: Patient rescripts chosen memory***
PAST	Good Parent Images Open cue: time when needed Good Parent Planned trauma work Fun Images
FUTURE	Hope

Imagery Rescripting HAM & VCM; Arntz Protocol

- Traditional Jeff Young Version

- Consistent switching of perspectives between Healthy Adult and VCM

- Arntz Version (2014)

- Start imagery with perspective of HAM and then start over with same image but with the perspective of the VCM.

Imagery Rescripting HAM & VCM; Arntz Protocol

Step 1

- Recall a childhood memory linked to EMS's and describes this in detail from the child's perspective.
- "see yourself as the little child back in that situation and describe what is happening"**
- Now that your uncle is at the top of the stairs, pause the image…what are you feeling, What is happening in your body? What are you thinking? What do you need?

Step 2

- Healthy Adult Rescripts
- HAM is instructed to notice the child in the image & meet the need and see it from the HAM perspective.
- "Bring you HAM in, what do you see happening, What do you do? How do you feel about the child being treated this way in the image?"

Step 3

- Child re-experiences the rescript
- Patient is asked to take the perspective of the VCM, having their need met by HAM; how does it feel?
- "Now rewind to when your HAM entered the Image and see her dealing with your uncle, how does she take care of you, how does that feel? Is there anything else you need? Ask your HAM for that?

Debrief

**Stop before anything "bad happens"

Demonstration – Follow along with the steps in the handout

Practice Imagery Re-scripting Arntz protocol

Using the Arntz Version of re-scripting with your own memory or your patient's memory.

Historical Role Plays to Strengthen *Perspective of HAM*

Historical role plays

Step 1

- Have client play their younger self and then explore their VCM thoughts and feelings (rate schema related beliefs)

Step 2

- Have client play the role of parent and then explore how that gave insight and awareness
- Discuss and check if the parent had the same thoughts as the VCM
- Plan with a more healthy response (with today's awareness)

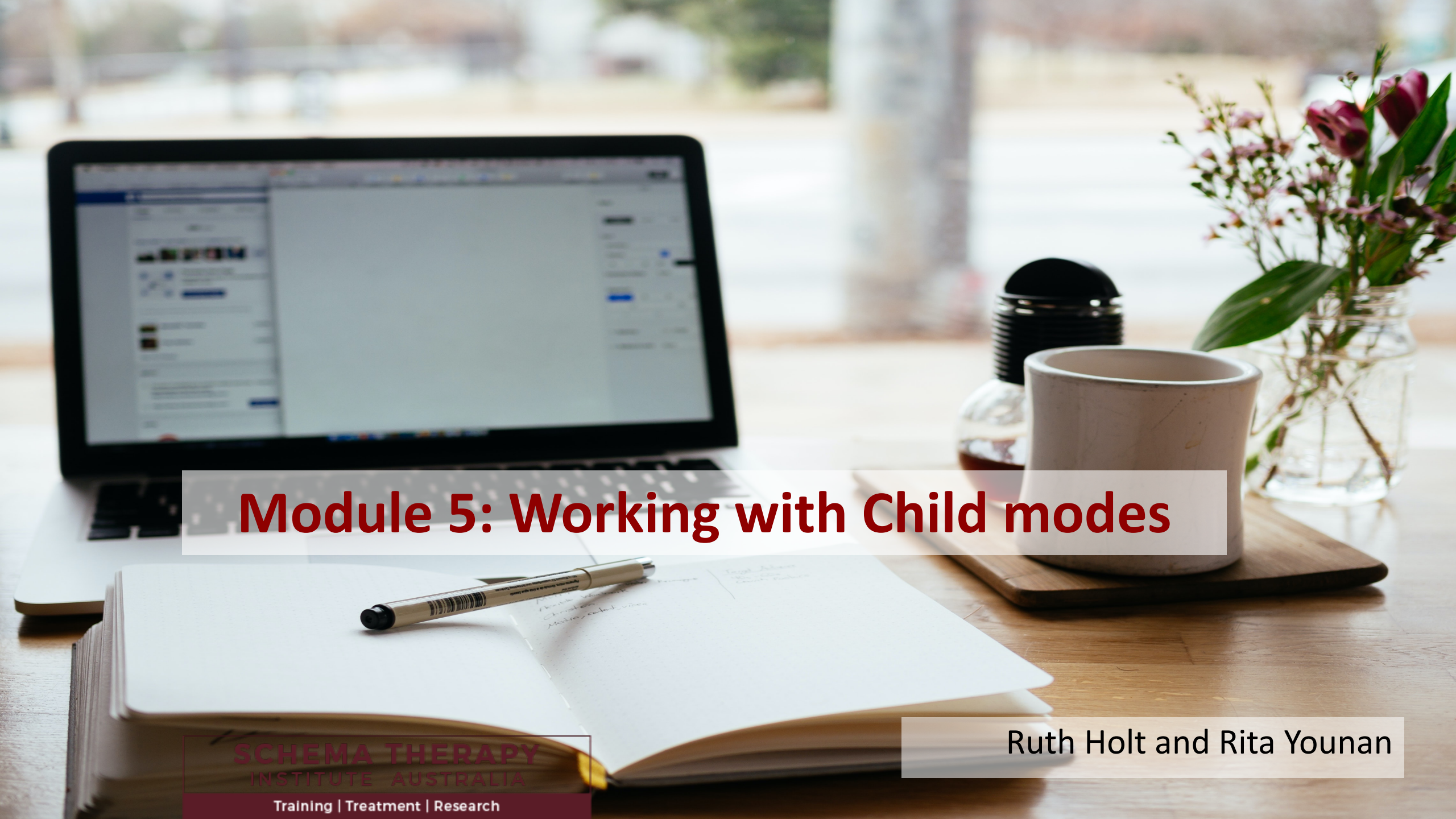
Step 3

- Have client play their younger self with the new responses
- Review VCM thoughts and feelings (re-rate schema related beliefs)

Demonstration – Step by step

Practice a Historical Role Play

Play a Rigid or Dependent patient and have familiarity with an important memory



Module 5: Working with Child modes

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Working with: *Child Modes*

Theoretical basis for Child modes

- Innate and Universal – all children are born with the potential to manifest them.
- Young's original child modes:
  - Vulnerable Child expresses most of the core schemas
  - Angry Child is the part that is enraged about unmet emotional needs and acts in anger without regard to consequences
  - Impulsive/Undisciplined child expresses emotions, acts on desires and follows natural inclinations in a reckless manner, without regard for consequences
  - Happy Child is one whose core needs are currently met

Angry Child

- Is a normal response when core needs are not met
- Often has been punished or squashed in childhood
- ACM is triggered by schema activation
  - Abandonment, Mistrust/Abuse, Emotional Deprivation, Subjugation etc
- yelling/angry “tantrums”/violent fantasies/lashing out verbally

Enraged Child

- Is an extreme response when core needs are not met
- “In enraged Child Mode you may get completely out of control. You may destroy things or even hurt other people. The enraged child is out of control, hits everything in its way, screams, and defends itself furiously against (assumed) attacks”
- Jacob et al.
- ECM is triggered by schema activation
    - Abandonment, Mistrust/Abuse, Emotional Deprivation, Subjugation etc

Impulsive/Undisciplined Child

- Is activated by needs for fun and/or autonomy
- May have developed as a result of critical or micromanaging parenting or neglectful parenting
- Often associated with schemas such as
    - Entitlement and Insufficient self-control
- Irresponsible behaviour/over

spending/over eating/risky

behaviour/laziness/carelessness

What about your Impulsive side?!

Undisciplined Child

“People with an Undisciplined Child Mode are don’t like to complete boring or annoying duties. It is very hard for them to take on normal, everyday responsibilities.

(they) are not always spoilt in the sense that they think that others will do their job for them, although that may happen, too. But often they simply live with important jobs not being done.

As children they never learned to sit with the frustration that goes along with boring tasks.”

Adapted from Jacob et al., 2014

Factors contributing to Impulsivity

The UPPS model of impulsivity – Whiteside & Lynam, 2001	
Urgency**	The tendency to give in to strong impulses when experiencing intense positive emotions The tendency to give in to strong impulses when experiencing negative emotions – depression, boredom and stress
Lack of Perseverance**	Ability to persist in completing tasks/obligations in spite of boredom or fatigue
Lack of Premeditation*	Ability to think through the potential consequences of his or her actions
Sensation seeking*	Preference for excitement and stimulation

*more likely in substance use, Antisocial PD and Conduct D
** more likely in BPD
All predict suicide attempts (except for sensation seeking)

Impulsivity and neurobiology

- Individuals exhibit elevated reward responsivity to relevant cues (temperament and/or neurology?)
- an imbalance between the top-down control – orbital prefrontal cortex and the anterior cingulate cortex and the bottom up drives generated in the limbic structure and the amygdala insulata
- act compulsively in the presence of these cues to satisfy intense cravings
- Cravings are also triggered by negative mood states, in which the drug or food may be used to regulate emotions (DSS)

Dawe, S., & Loxton, N. J. (2004)

Impulsive child and addiction

Impulsivity is a risk-factor for whether an individual develops an addiction, chronic substance use and may also lead to worsening executive control deficits throughout the course of the addiction. Addicted individuals typically show dysfunction in brain regions associated with impulsivity during decision-making tasks and are impaired at delaying gratification of rewards

(Hoffman et al., 2008)

Research on modes and addiction

	F (df)	*p* value	Partial eta squared	Pairwise comparison
"Detached self-soother"	10.68* (2, 153)	≤0.001	0.12 (medium effect size)	Cocaine/alcohol > control
"Detached protector"	3.92 (2, 153)	0.02	0.05 (small)	Cocaine > control
"Self-aggrandizer"	0.56 (2, 153)	0.57	0.01	–
"Bully and attack"	1.71 (2, 153)	0.18	0.02	–
"Vulnerable child"	9.99* (2, 153)	≤0.001	0.12 (medium)	Cocaine/alcohol > control
"Angry child"	7.27* (2,153)	≤0.001	0.09 (medium)	Cocaine > control
"Impulsive child"	8.51* (2,153)	≤0.001	0.10 (medium)	Cocaine/alcohol > control
"Punitive parent"	11.05* (2, 153)	≤0.001	0.13 (medium)	Cocaine/alcohol > control

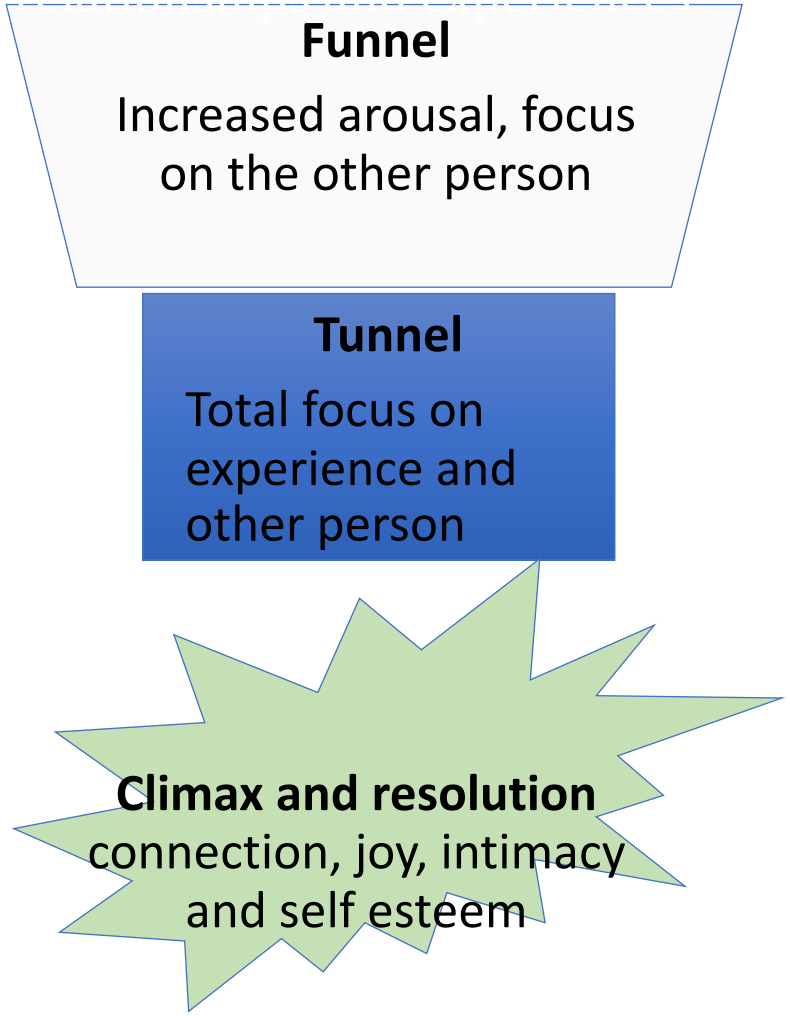
* Significant after Bonferroni adjustment.

Boog, M., Van Hest, K. M., Drescher, T., Verschuur, M. J., & Franken, I. H. (2018). Schema modes and personality disorder symptoms in alcohol-dependent and cocaine-dependent patients. *European addiction research*, *24*(5), 226-233.

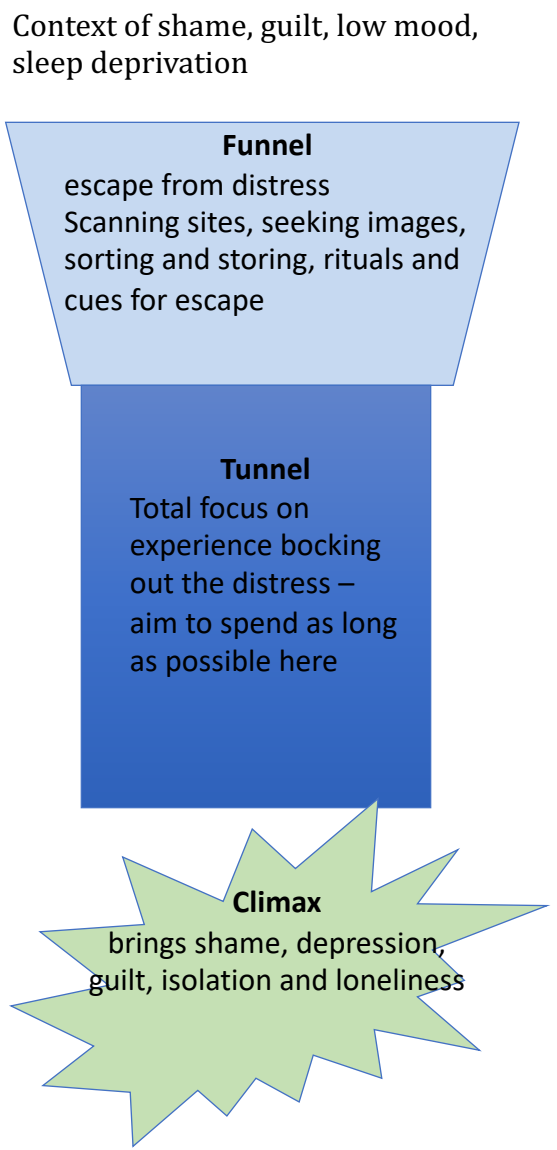
Impulsive child and other modes in problematic pornography

Tunnel and funnel model, cited in Watts, 2014

“Normal” sexual response and activity



Problematic porn use



Tunnel and funnel model, cited in Watts, 2014

Demonstration of mode work with Impulsivity

Impulsive child and eating

- Often there is high attention to cues for eating, difficulty distracting and multiple triggers
- IC often involved in early stages “I like the taste”, “look that’s exciting” and then in the continuation of binging “I’ve blown it so why stop”

Ways to empathically confront IC:

“Let’s see if we can give IC something exciting to do to distract her while HA goes grocery shopping”

“when you are getting your morning coffee could HA talk to IC and remind him that he is having a drink with friends after work, he doesn’t need all his fun by 10am”

Susan Simpson on child modes and eating

"In EDs, the Impulsive Child/Undisciplined Child are often rebelling against the control of the Demanding Parent and/or Overcontroller mode, so we may need to deal with that first, so there is less of a need for rebellion …

Demanding Parent, Overcontroller mode – may need to deal with first

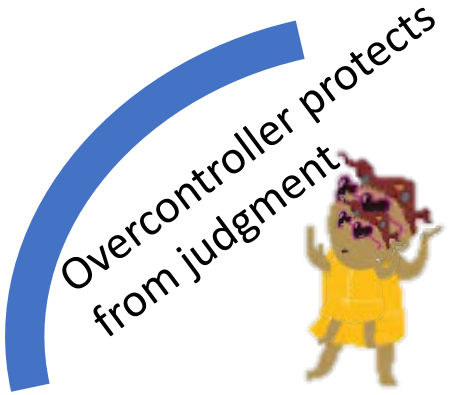
IC/UC

Susan Simpson on child modes and eating

“there is often a significant attachment to the Impulsive Child/Detached Self-Soother duo, and which can feel like a safe-substitute for connection and love. I also find that in many cases, patients with EDs have been given the message that they are out-of-control, or 'too much' by parents who are emotionally inhibited and who can’t tolerate the normal spontaneity and impulsivity of their child.

Susan Simpson on child modes and eating

“The child learns to doubt (or even mistrust) their own body signals, and begins to fear this spontaneous side of themselves. The Overcontroller mode develops as a mechanism to shut-down this unpredictable side of themselves - so that they won’t be judged or deemed a burden by others.

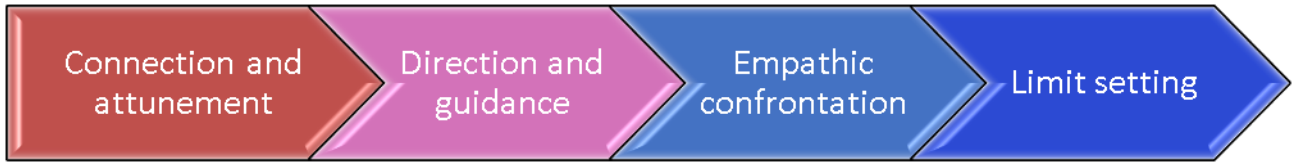


Susan Simpson, ISST Listserve discussion, 15/2/20

Practice a exploring the modes in impulsive behaviour

Play a client with impulsive behaviour (where you know their childhood history) and map out the modes.

ST Techniques with Coping Modes: Therapy Relationship



- Limited Reparenting to down-regulate Defence
- Empathic Confrontation & Limit-Setting where needed
- Authentic & Honest Approach (modelling & self-disclosure)
- Encouraged to Express Needs in Session
- *Mixture of meeting attachment needs **and need for limits***

Therapeutic Attitude for Attachment Probs: PACE, Hughes, 2006

- Playfulness
- Acceptance
- Curiosity
- Empathy

Obstinate Child

- Is activated by needs for safety and/or autonomy
- May have developed as a result of critical or micromanaging parenting, neglectful parenting or abuse
- Often associated with schemas such as
    - Entitlement and Insufficient self-control or Mistrust/Abuse
- The ‘inner donkey’ who unreasonably says no to everything, has a pouting/irrational quality

The Narcissistic "Lonely Child"

Treatment Goals

- Help the client accept that there is a lonely child – buried under coping modes
- Help the lonely child to feel nurtured and understood (which will help the coping modes reduce) – Imagery and Limited Re-parenting
- Help the lonely child to connect to others in imagery, then in real life

The Antisocial "Inferior/shamed Child"

Treatment Goals

- Help the client accept that there is a Inferior/shamed child – buried under coping modes
- Help the child to feel nurtured, accepted and worthy (which will help the coping modes reduce) – Imagery and Limited Re-parenting
- Help the child to connect and trust appropriate others in imagery, then in real life

Dependent PD

Dependent Child *or* Abandoned Abused

Avoidant PD
Lonely/Inferior or Abandoned Abused

OCPD Vulnerable Child Mode – usually inaccessible

Interview with David Bernstein about connecting with these clients

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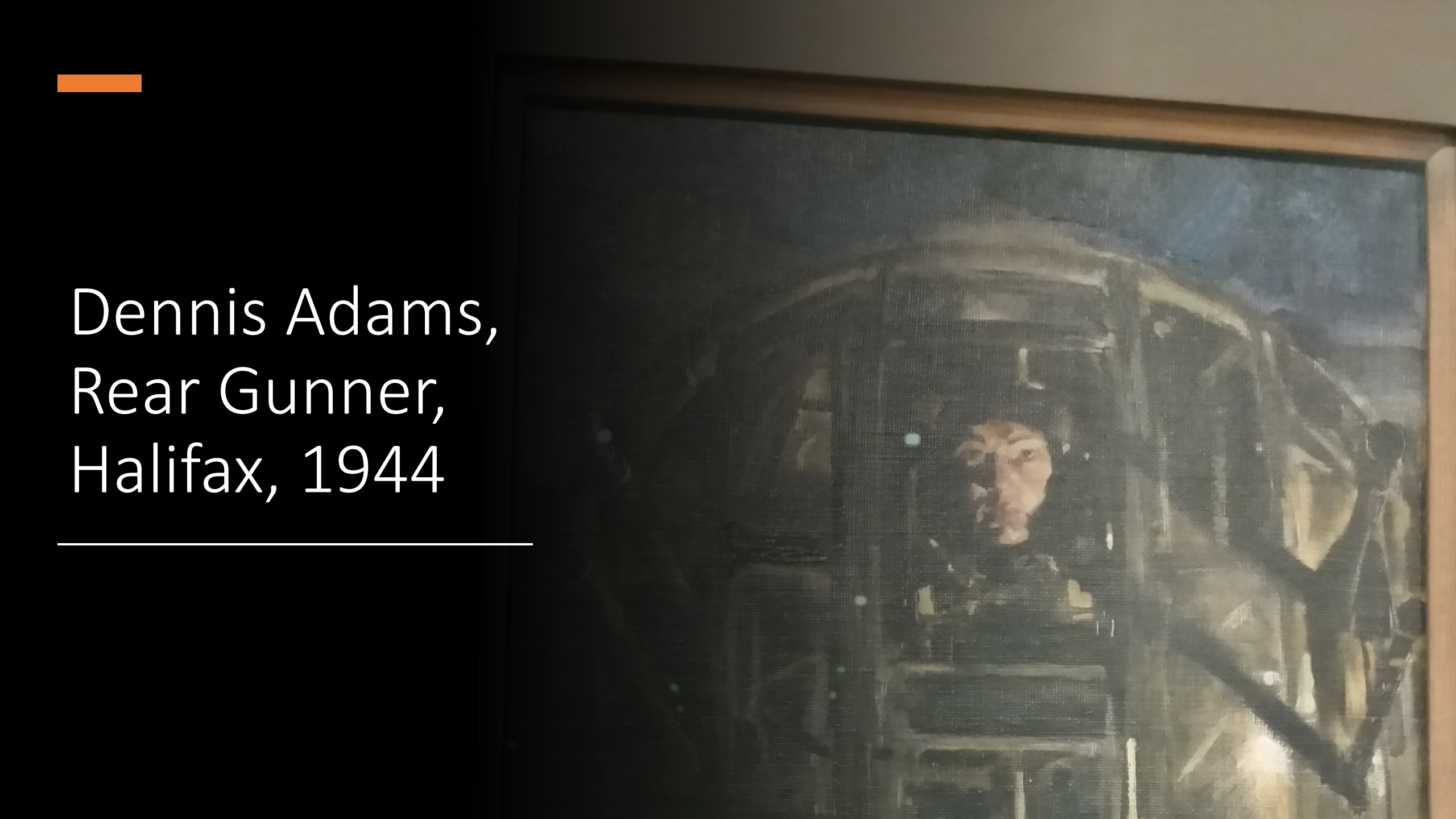
Dennis Adams, Rear Gunner, Halifax, 1944



Identifying a child mode

- “The simplest way to recognize a mode is by its feeling tone” Young et al 2003
- Child modes often ‘feel’ young, are not particularly well thought out and often clients are surprised or confused by them
- Don’t get too caught up in the definitions of the mode because each client will have a unique presentation of a child mode
  - eg an impulsive child mode connected to an entitlement schema will be different from an impulsive child mode based on an abandonment schema

Unhelpful child mode reflect a lack of core Healthy Adult skills

Core skills missing in all child modes

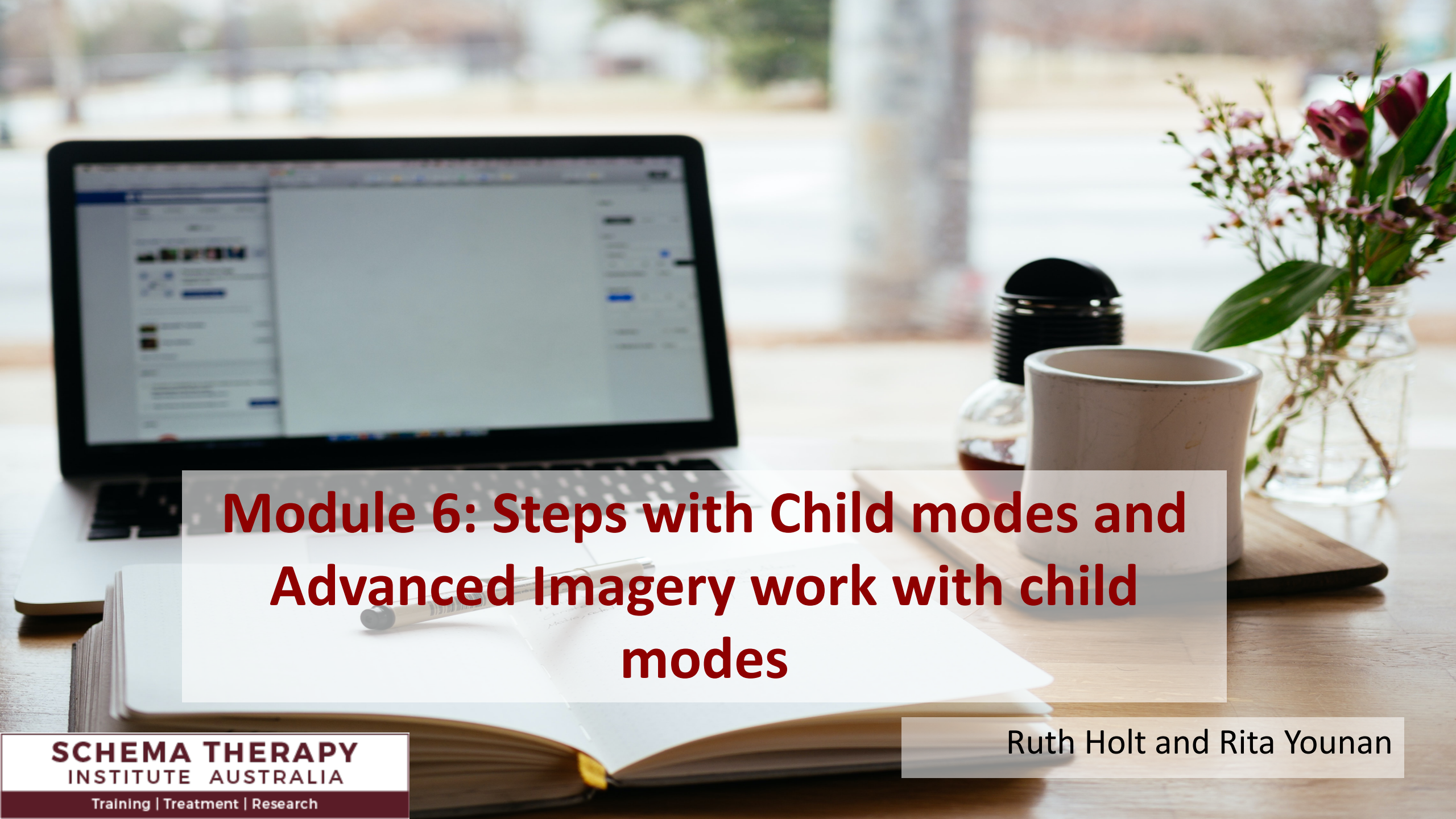
- Ability to notice distress and respond by meeting needs effectively
- Distress tolerance – including the ability to notice what part of the distress is related to the current situation and what is schema activation from the past
- Delayed gratification
- Problem solving skills
- Assertiveness skills
- Soothing skills

For each unhelpful child mode there are specific Healthy Adult skills missing

Child Mode	Missing Healthy Adult skills
Angry and Enraged	Noticing anger in the early stages and using cognitive/emotional /behavioural skills to manage effectively Pre-emptive planning in common triggering situations
Impulsive Child	HA approach to weight/food/fun/drug/alcohol/socialising rather than the boom bust cycle of critic and IC Ability to tolerate cravings and develop alternate coping strategies to regulate intense mood states Healthy ways to meet high sensation seeking needs Maintain longer term perspective/consequence awareness
Undisciplined Child	Healthy ways to meet need for rest Setting manageable goals Intrinsic motivation skills – positive self statements, agency, valuing process and outcome
Obstinate Child	Ability to understand needs and communicate effectively Empathy and negotiating skills

Child modes trigger therapists

- Angry/Enraged child
  - T can get defensive
  - T can be too empathic with ACM and neutralize anger
  - T can counterattack
  - T can withdraw psychologically
  - T can be too passive and patient becomes abusive
- Undisciplined/Impulsive child
  - T's Demanding or Punitive Critic can get activated
  - T can find it difficult to empathise or assume that there is more HA capacity than the client has



Module 6: Steps with Child modes and Advanced Imagery work with child modes

Ruth Holt and Rita Younan

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Steps in treating Child modes

1. Notice and identify child modes
2. Understand origin of mode, connections to schemas and unmet childhood needs
3. Build client awareness
4. Set limits in therapy as needed
5. Experiential work to reduce child mode and increase Healthy Adult
6. Behavioural pattern breaking

1. Notice and Identify Mode

Curiosity and empathy are key to getting the child mode to open up – just like with an actual child a sense of playfulness and a non judgmental stance will draw out the child mode

“I wonder if there’s a part of you that just wants to trash the place?”

“ I am hearing a side of you that says ‘stuff it’/ ‘no,no,no,no,no’, ‘you can’t make me’, is that right?”

2.Understanding

- What are typical triggers of your Angry/Enraged/Obstinate/ Impulsive Child Mode? In which situations does it get activated?
- What feelings are dominant in that Mode? Is it more about frustration, anger, rage, or defiance? Do you feel more strong or weak in this Mode?
- Is your Child Mode usually followed by a Vulnerable Child Mode? Or is it the other way round?
- What thoughts are typical of this Mode? If you feel unjustly treated – what is the injustice?
- What memories and mental images are related to this Mode?
- How do you typically act in this Mode? How do you react to others and how do others react to you?
- Does that remind you of something in your childhood?
- What do you need?

Adapted from Jacob et al., 2014

3. Client awareness - Mode monitoring

- Start with noticing body sensation/typical triggers
- Add awareness of thoughts and memories connected to mode
- Add needs - both VC and other child mode
- Add mode flips, before and after

4. Setting limits

- Angry Child ventilate, not Enraged child (see complex trauma training more info)
- Angry/Enraged child in session
  - Base limits on client safety and therapist's rights
  - "I understand you are angry and I welcome your anger, but it's not OK to throw anything in this room"
  - "I can see you are really upset and I want to hear you, but when you shout I can't listen the way I want to"
  - Increase severity of consequences if needed

" If this continues I will need to stop the session/call the crisis team/pause treatment to keep us both safe"

Setting limits

- Impulsive child prior to therapy
- External sources of behaviour management may be important – rehabilitation / sobriety or for safety reasons
  - Increase severity of consequences if needed

  “ If this continues I will need to stop the session/call the crisis team/pause treatment to keep us both safe”

Setting limits

- Obstinate and Undisciplined child in session
  - Make sure it's not Avoidant or Detached protector, then
  - Base limits on client goals and therapist's rights

  "I understand you haven't had anyone help with how to do these tasks and it's easy to give up, but there's a part of you (and me) that wants things to change"

  "I can see you are really upset and I want to be there for you, but when that side of you digs their heals in it's hard to know what you really need"
  - Increase severity of consequences if needed

  " If we can't find a way to make small steps outside of session we will need to pause for a month"

5. Experiential work with child modes

- Mode dialogues
  - Increase understanding by interviewing child mode – what do they need?
  - Increase motivation by having the child mode talk to the VC and/or the Healthy adult mode
  - Future events - agreement with child mode about how HA is going to meet their needs

Experiential work with child modes

- Imagery Re-scripting
  - Increase understanding by going back to origin of mode
  - Bring Healthy Adult (initially the therapist) in to the scene and meet the needs of both the unhelpful child mode and the VC
  - Future events planning with child mode about how HA is going to meet their needs

Main Types Of Rescripting

PRESENT	Safety Images Response to flashbacks (intrusive images) Nightmares
PRESENT TO PAST	Imagery rescripting via affect bridge Phase one Therapist: Imagery rescripting of chosen memory/***Phase two: Patient rescripts chosen memory***
PAST	Good Parent Images Open cue: time when needed Good Parent Planned trauma work Fun Images
FUTURE	Hope

Practice Imagery Re-scripting for an Impulsive Child or Angry Child

Stop and discuss after step 4

and step 6 – brainstorm together what to do

What if a client is getting stuck in anger?

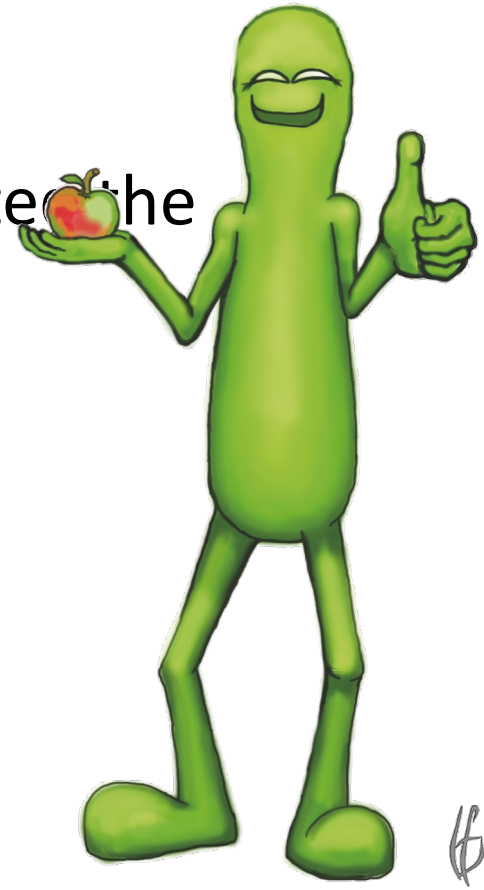
"It is important that clients do not get stuck 'just feeling intense rage' or 'impotent rage' (raging but feeling hopeless too) and can eventually move on to maybe forgiveness (being clear about what forgiveness is and what it is not). Indeed, some individuals who are very 'happy' being angry may actually be avoidant of other emotions such as sadness or loneliness. So any emotion can be used as a safety strategy to block another." Paul Gilbert, 2014

6. Behavioural pattern breaking

- Often child modes have ‘friends’ – others who encourage/enable/profit from the mode, which will make change harder if not identified
- What are the situational triggers?
- Bringing Healthy Adult into those situations – imagery/role playing/reminders of experiential work/flash cards
- Rewards!

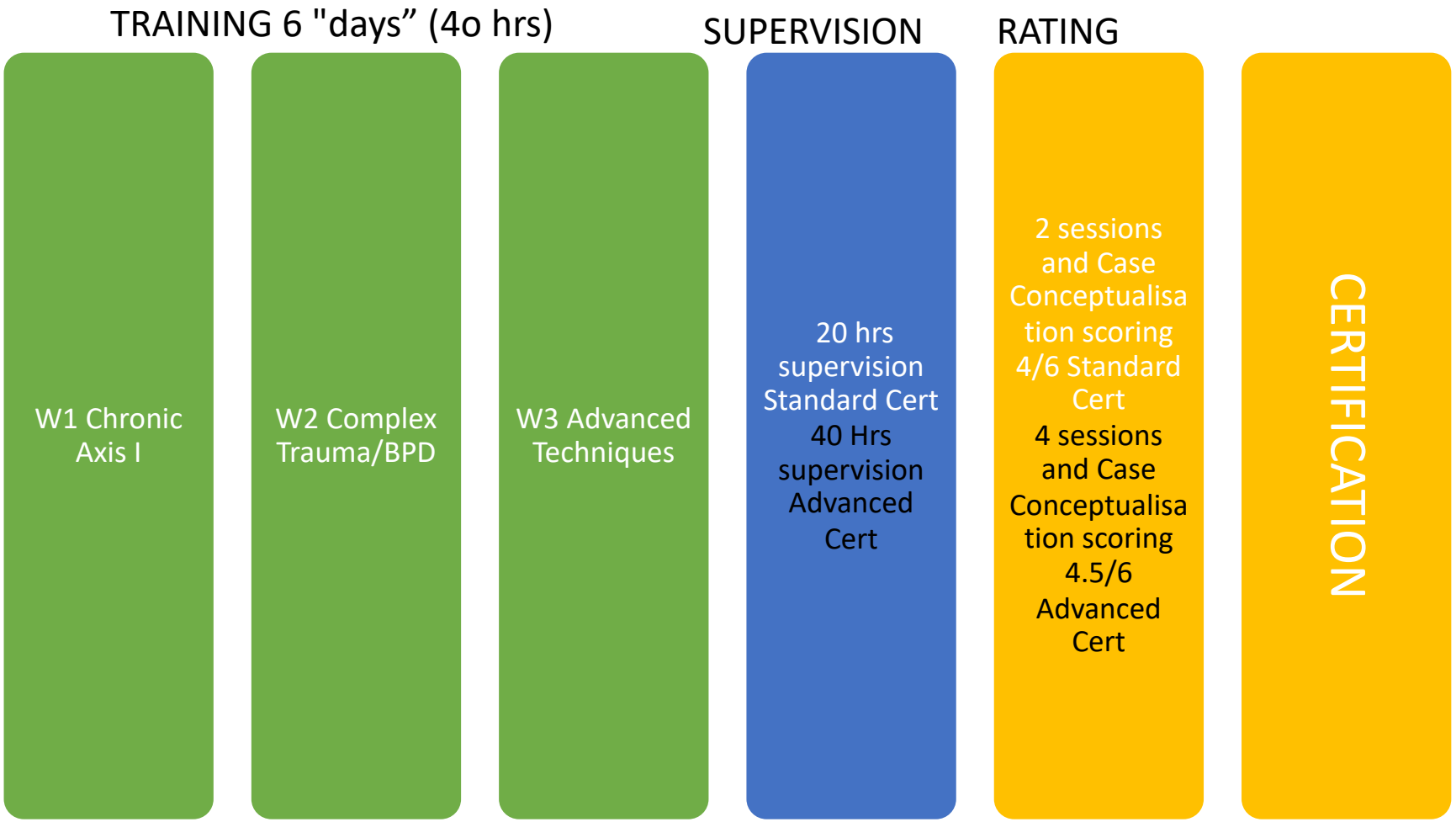
Reminder: Behavioural Pattern Breaking In Schema Therapy

- Autonomy Stage in ST – Stronger HAM at this stage, introjected the therapists “Good Parent” Voice
- Role Plays
- Flash Cards
- Skills Training
- Psychoeducation and Coaching
- Mode Management Plans
- Changing schema driven patterns in Imagery to transfer to reality.



Walking through the modes

ISST Certification as a Schema Therapist



We would like your feedback!

- You will be sent a survey monkey invite for complete a 2 min survey
- ISST requirement

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