ANOUSHA HADINIA & JAN KOSSACK

SCHEMA THERAPY

online training for the ISST certification
(International Society for Schema Therapy)

JAN KOSSACK

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

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DATES OF THE TRAINING

MODULE 1:
06 & 07 JANUARY 2024
BY JAN KOSSACK

MODULE 2:
20 & 21 JANUARY 2024
BY JAN KOSSACK

MODULE 3:
27 & 28 FEBRUARY 2024
BY DR. ANOUSHA HADINIA

MODULE 4:
13 & 14 MARCH 2024
BY DR. ANOUSHA HADINIA

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

PRESENTATION OF PARTICIPANTS

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

THE PROGRAM

AGENDA

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

MODULE 1

1.1. Schema theory / concept

- schemas, coping styles and modes: defined and differentiated

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

- the needs / rights of the child

1.2. planning the treatment & conceptualization of a case

- clarifying goals in the context of patterns and modes

- case conceptualization in terms of patterns and modes

concept...
and
the general
context

1.1. SCHEMA THEORY

OVERALL CONTEXT:

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

OVERALL CONTEXT (2):

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

OVERALL CONTEXT (3):

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

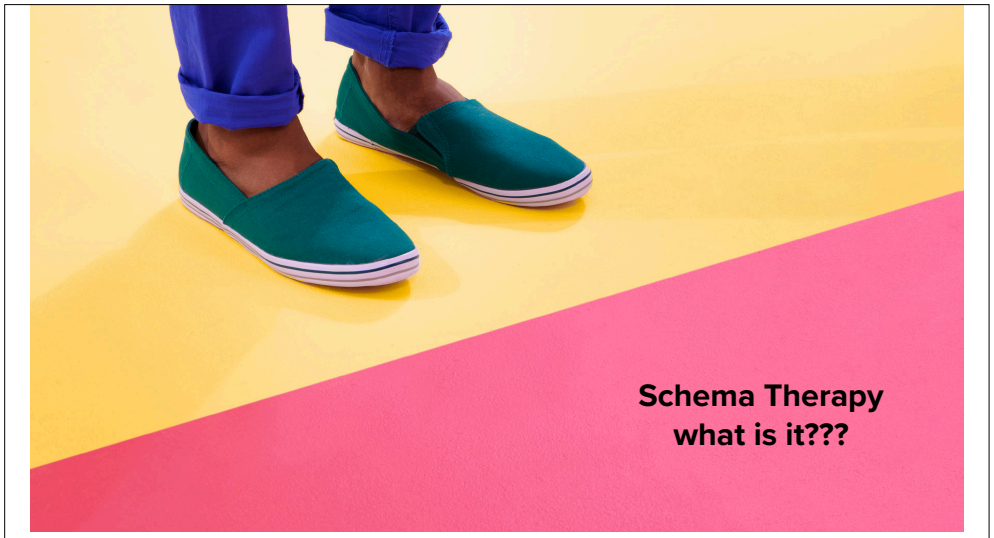
Farrel, Shaw and Belhourania 2021

EMPIRICAL VALIDATION...

- The effectiveness of ST in patients with Borderline personality disorder has been empirically validated in several large-scale studies of individual ST

- (Giesen-Bloo et al. 2006; Nadort et al. 2009; Farrel, Shaw, and Webber 2009; Reiss, Lieb, Arntz, Shaw, and Farrell 2014; Dickhaut and Arntz 2014; Bamelis, Evers, Spinhoven, and Arntz 2014; Bernstein et al. 2012;...)
- Farrel, Shaw, and Belhourania 2021

Farrel, Shaw et Belhourania 2021



CORE CHILDHOOD NEEDS

- **core physical needs**
- **core emotional needs**

CORE PHYSICAL NEEDS

- **drink**
- **eat**
- **sleep**
- **breathing**

THE 5 CORE EMOTIONAL NEEDS

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

ATTACHMENT

Safety, stability, care, acceptance, care and protection

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

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

AUTONOMY

I know my skills.

I can face challenges and new situations independently.

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

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

EXPRESSING NEEDS AND EMOTIONS

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

My caregivers care about and respect my feelings and needs.

BEING PLAYFUL AND SPONTANEOUS

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

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

REALISTIC LIMITS

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

I know and respect social rules.

I am able to control my emotions and behaviour.

THE FIRST CUT IST THE DEEPEST....

STILL FACE - ED TRONICK

HTTPS://YOUTU.BE/APZXGEBZHTO

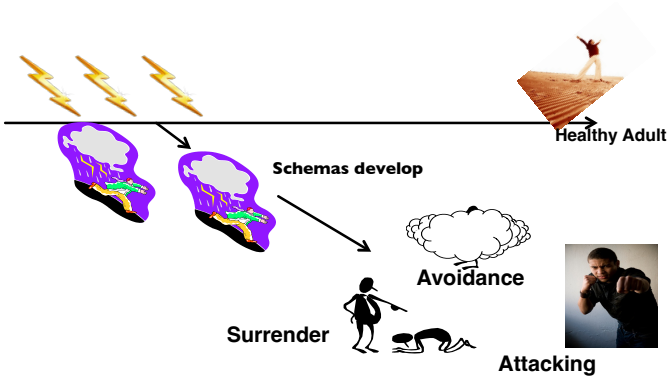
CENTRAL IDEAS OF SCHEMA THERAPY

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

LES BESOINS AFFECTIFS FONDAMENTAUX ET LA „ATTACHEMENT THEORY"

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

SCHEMAS & COPING



WE ALL HAVE SCHEMAS!

WHAT ARE SCHEMAS?

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

DEFINITION OF EARLY MALADAPTIVE SCHEMAS:

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

SCHEMAS ARE LIKE

FILTERS OR GLASSES

THE DOORBELL METAPHOR

SCHEMA DOMAINS:

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

DOMAIN I: SEPARATION AND REJECTION

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

unmet need:

secure attachment

DOMAIN II: LACK OF AUTONOMY AND PERFORMANCE

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

Unmet need:

autonomy

DOMAIN III: LACK OF BOUNDARIES

- Entitlement Schema
- Schema of insufficient self-control

Unmet need:

Realistic limits

DOMAIN IV: ORIENTATION TOWARDS OTHERS

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

Unmet need:

express my needs and emotions

DOMAIN V: OVER-VIGILANCE AND INHIBITION

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

Unmet need:

Being playful & spontaneous

VIDEO: STARTING THERAPY WITH LUCY

WHAT WERE THE THERAPIST'S GOALS?

WHAT INFORMATION DID SHE LOOK FOR?

THE SCHEMAS

Examples videos

ABANDONMENT / INSTABILITY

People with this schema are convinced that important relationships will never last and therefore, they are constantly faced with the fear of being abandoned or disappointed by others. They feel lonely and abandoned, with no one to reliably provide protection, emotional support, connection or warmth.

People with this profile report childhood experiences of abandonment, such as abandonment by a parent, untimely death of important caregivers, or frequent loneliness.

FILM ABANDONMENT SCHEMA

MISTRUST & ABUSE

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

EMOTIONAL DEPRIVATION

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

DEFECTIVENESS / SHAME

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

FILM DEFECTIVENESS / SHAME

SOCIAL ISOLATION

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

DEPENDENCY SCHEMA

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

VULNERABILITY

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

ENMESHMENT SCHEMA

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

FAILURE SCHEMA

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

FILM LITTLE ISBALLE (JEFF & WENDY)

ENTITLEMENT SCHEMA

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

INSUFFICIENT SELF-CONTROL SCHEMA

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

SELF-SACRIFICE SCHEMA

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

SUBJUGATION SCHEMA

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

APPROVAL SEEKING SCHEMA

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

NEGATIVITY SCHEMA

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

EMOTIONAL INHIBITION

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

UNRELENTING STANDARDS SCHEMA

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

PUNITIVENESS SCHEMA

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

EXAMPLE:
MARIE
21 YEARS OLD
BORDERLINE PERSONALITY DISORDER

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

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

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

She has been living with her boyfriend for some time.

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

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

She feels anxious.

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

She imagines that Paul is with another woman.

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

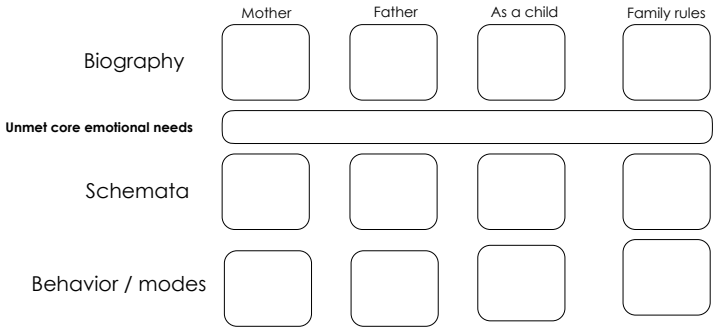
When Paul comes home at 6:30 p.m., Mary can't control herself.

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

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

UpgradeYourLife
Counseling & Psychotherapy by Jan Kossack

SCHEMA FORM FOR MARIE:



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

20min

SCHEMA THERAPY GENERAL APPROACH:

2 PHASES IN SCHEMA THERAPY

- **Diagnostic & Psychoeducation**

- **Change**

INITIATING SCHEMA THERAPY

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

IDENTIFY „LIFE PATTERNS“

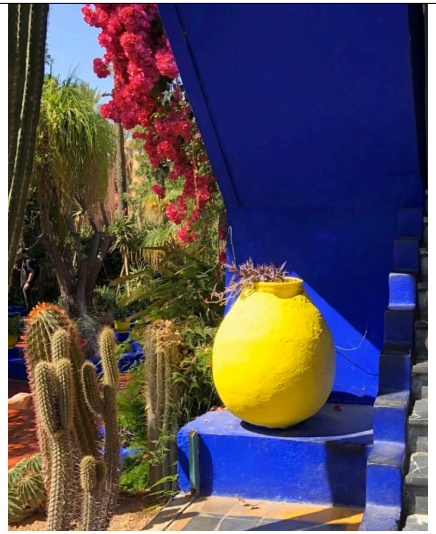
- conduct a life history interview
- look for patterns related to current problems, such as partner choice ("schema chemistry"), job or career problems, relationship conflicts

EDUCATE PATIENTS ABOUT THE APPROACH

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

DIAGNOSTIC

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



IMAGERY

IMAGERY:

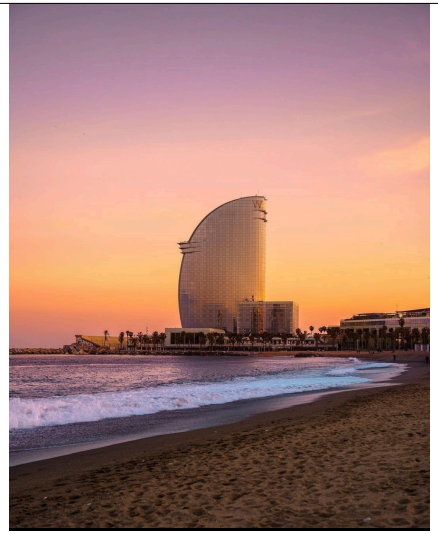
DIAGNOSTIC IMAGERY

IMAGERY RESCRIPTING

IMAGERY

PRINCIPES

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



DIAGNOSTIC IMAGERY - REMCO - STEP BY STEP

DIAGNOSTIC IMAGERY PROCESS - 1

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

DIAGNOSTIC IMAGERY : PROCESS - 2

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

DIAGNOSTIC IMAGERY: PROCESS - 3

the AFFECT BRIDGE...

- tell the patient to feel his feelings (physical and emotional) now, he must stay with these feelings

- but let the image of the present situation disappear and let it drift into the past, and let possible images from the past arise in which he felt the same way.

DIAGNSOTIC IMAGERIE : PROCESS - 4

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

DIAGNOSTIC IMAGERY: PROCESS - 5

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

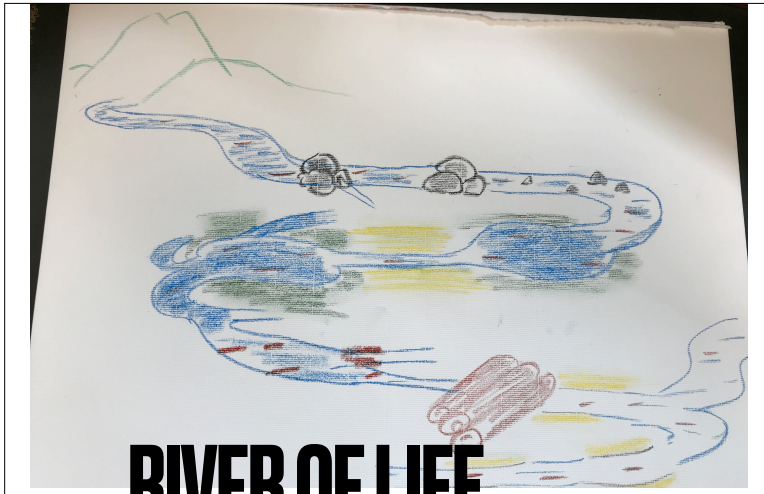
DIAGNOSTIC IMAGERY : PROCESS - 6

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

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

each person as a therapist ONCE

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



RIVER OF LIFE

a possibility to get ideas on schemas of the patient

RIVER OF LIFE - 1

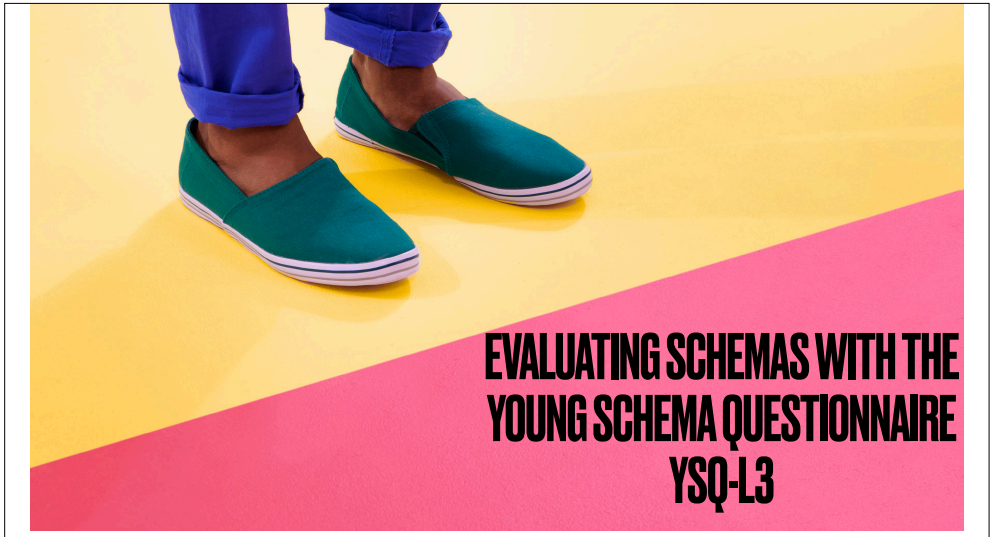
- I want to get to know you better today.
- I want to ask you to draw a picture of your life. But imagine that your life is a river.
- A river usually starts with a small spring. At first it's a small stream, then it gets bigger and bigger.
- It's like us.
- I like the comparison to a river, because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

RIVER OF LIFE- 2

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

QUESTIONNAIRES

DE JEFFREY YOUNG



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

M 127 -

YSQ – L3

Jeffrey Young, Ph.D

Name _____ Date_____

INSTRUCTIONS:

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

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

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

RATING SCALE:

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

EXAMPLE:

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

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

ref

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

M137

Scoring Sheet for
Young Schema Questionnaire
L3

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

M138

Interpretation Grid for
Young Schema Questionnaire – L3

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

OTHER QUESTIONNAIRES

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

SMI (Version 1.1)

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

FREQUENCY: In general

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

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

- FIGHT
- FLIGHT
- SURRENDER

3 COPING STYLES

COPINGS STYLES

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

KEY TO THERAPY

WORKING WITH MODES

THE MODES

DEFINITION

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

THE MODES...

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

DIFFERENT KIND OF MODES:

- Child modes

- dysfunctional parent modes

- coping modes:

a) avoiding modes

b) over-compensation modes

c) surrender mode

- healthy modes

CHILD MODES

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

DYSFUNCTIONAL PARENT MODES

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

THE MODES IN THE COPING STYLES…

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

DETACHED PROTECTOR MODE

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

THE DETACHED SELF-SOOTHER MODE

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

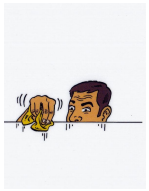
THE COMPLAINING PROTECTOR MODE

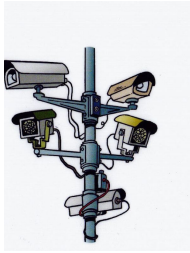
THE STIMULATION / KICK SEEKING MODE

THE OVER-COMPENSATION

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





HEALTHY ADULT MODE

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

HAPPY CHILD MODE

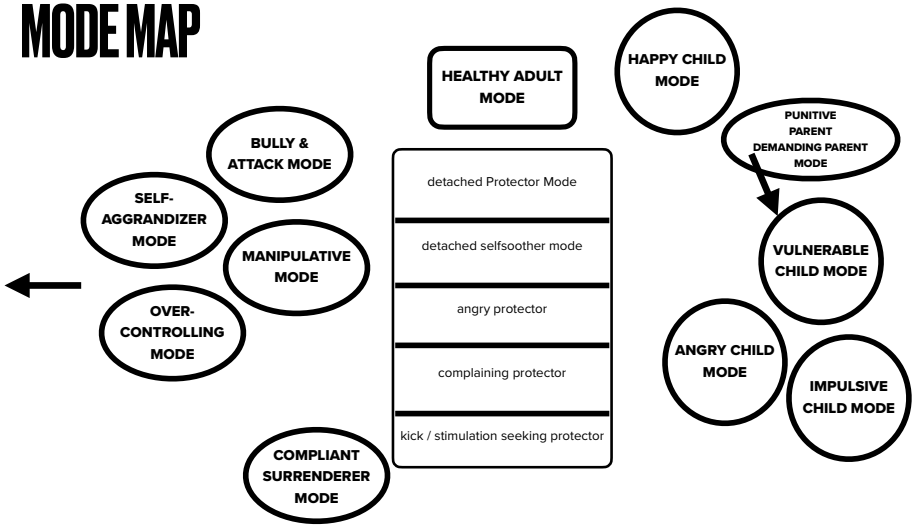
MODE-CARDS DE PROF. DAVID BERNSTEIN:

WWW.I-MODES.COM

INTRODUCE THE MODES (REMCO – STEP BY STEP)

DISCUSSING THE MODE MODEL (STEP BY STEP – MARJON)

MODE MAP



SPEAKING OF MODES...

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

GENERAL STRATEGIES IN WORKING WITH MODES

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

WHAT MODE IS THIS?

Video David Bernstein

SCHEMA THERAPY ACADEMY
by A. Hadinia & J. Kossack

EXERCICE: MODE MODEL

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

MODES IN ANTISOCIAL PERSONALITY

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

MODES IN THE PSYCHOPATHIC PERSONALITY

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

TREATMENT PHILOSOPHY

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

FIRST STEP: THE THERAPEUTIC ALLIANCE AND THE EMOTIONAL REGULATION

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

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

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

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

RECOGNIZE THE DETACHED PROTECTOR::

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

GENERAL STRATEGIES IN WORKING WITH THE DETACHED PROTECTOR

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

GENERAL GOALS IN WORKING WITH THE DETACHED PROTECTOR

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

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

Jeffrey Young

FILM: DETACHED PROTECTOR IDENTIFYING MODES

2 PHASES OF SCHEMA THERAPY

- Diagnostic & Psychoeducation

- Change

GENERAL STRATEGIES TO CHANGE SCHEMAS

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

EXPERIENTIAL STRATEGIES FOCUSED ON EMOTION: :

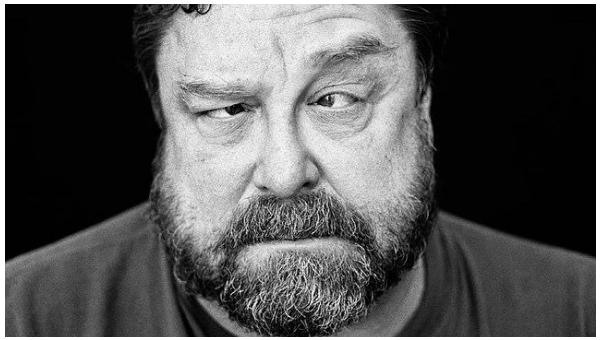
- limited reparenting
- imagery rescripting
- empathic confrontation
- chair-work
- ...
- look at examples...

CASE CONCEPTUALIZATION

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

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

LET'S HAVE A LOOK AT THE FILLED IN EXAMPLE



I. CASE CONCEPTUALIZATION

What you can do…

SCHEMA THERAPY ACADEMY
by A. Hadinia & J. Kossack

CASE CONCEPTUALIZATION

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

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WE NEED INFORMATION!

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

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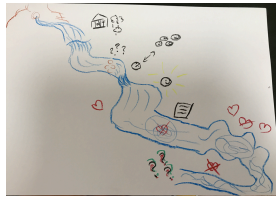
IDENTIFY THE PATTERNS

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



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IDENTIFY THE LIFE PATTERNS

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

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PSYCHOEDUCATION

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

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EVALUATE THE QUESTIONNAIRES

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

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USING THE RESULTS OF THE YSQ-L3

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

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ASSESSMENT OF THE ORIGINS DURING CHILDHOOD & ADOLESCENCE

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

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EMOTION-FOCUSED TECHNIQUES FOR THE ASSESSMENT OF SCHEMAS AND MODES

Diagnostic imagery (1):

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

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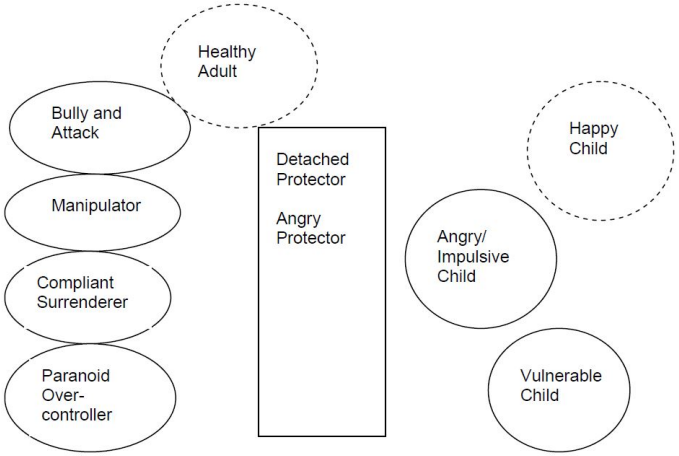
DIAGNOSTIC IMAGERY (2)

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

MODE MAP



II. THE THERAPEUTIC RELATIONSHIP

ATTACHEMENT

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

CORE EMOTIONAL NEEDS

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

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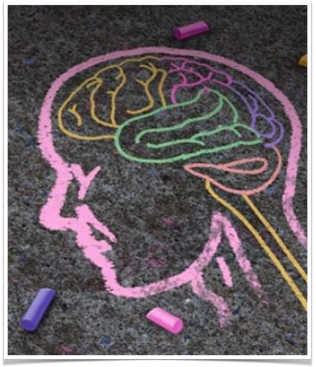
NEEDS & ATTACHEMENT

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



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UNIVERSAL QUESTIONS FOR ATTACHMENT

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

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AND THESE QUESTIONS ALSO COUNT IN THE THERAPEUTIC RELATIONSHIP

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THERAPEUTIC RELATIONSHIP

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

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THERAPEUTIC RELATIONSHIP IN THE DIAGNOSTIC PHASE

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

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1. THE THERAPIST ESTABLISHES THE COLLABORATIVE RELATIONSHIP (1)

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

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1. THE THERAPIST ESTABLISHES THE COLLABORATIVE RELATIONSHIP (2)

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

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2. THE THERAPIST CONCEPTUALIZES THE CASE (1)

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

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2. THE THERAPIST CONCEPTUALIZES THE CASE (2)

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

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

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

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

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4. THE QUALITIES OF THE IDEAL SCHEMA-THERAPIST

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

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

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

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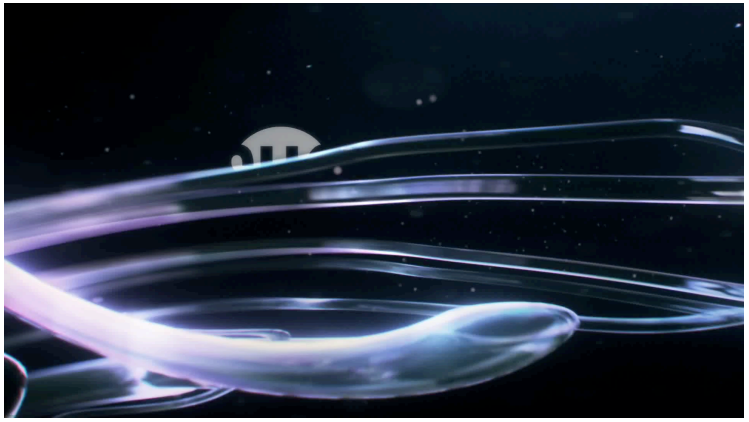
4. THE QUALITIES OF THE IDEAL SCHEMA-THERAPIST (3)

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



no, no, no… :)

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CRITERIA FOR CERTIFICATION

_____ 2. COMPRÉHENSION ET HARMONISATION

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

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

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

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

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CRITERIA FOR CERTIFICATION

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

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

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

_____ 13. UTILISATION DE LA RELATION THÉRAPEUTIQUE DANS LE CHANGEMENT

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

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

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

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

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

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

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THE THERAPEUTIC RELATIONSHIP IN THE PHASE OF CHANGE

1. limited re-parenting
2. empathic confrontation

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LIMITED RE-PARENTING

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LIMITED REPARENTING DEFINED

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

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

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

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

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CORE COMPONENTS OF LIMITED REPARENTING

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

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EDUCATE THE CLIENT - MORE LIMITED REPARENTING

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

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INDIVIDUALIZE THE RE-PARENTING PROCESS BASED ON NEEDS

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

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EXERCISE: LIMITED RE-PARENTING

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

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

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SET BOUNDARIES WITH THE BULLY & ATTACK MODE

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

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

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EXERCISE: SET BOUNDARIES

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

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OTHER FORMS OF LIMITED RE-PARENTING

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

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RISKS & SAFEGUARDS FOR THE LIMITED RE-PARENTING

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

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TRAPS & SCHEMAS OF THE THERAPIST (1)

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

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TRAPS & SCHEMAS OF THE THERAPIST (2)

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

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INTENSIVE LIMITED RE-PARENTING

SCHEMA THERAPY ACADEMY
by A. Hadinia & J. Kossack

INTENSIVE LIMITED RE-PARENTING BY JEFFRY YOUNG (1)

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

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INTENSIVE LIMITED RE-PARENTING BY JEFFREY YOUNG (2)

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

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INTENSIVE LIMITED RE-PARENTING BY JEFFREY YOUNG (3)

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

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INTENSIVE LIMITED RE-PARENTING BY JEFFRY YOUNG (4)

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

INTENSIVE LIMITED RE-PARENTING BY JEFFRY YOUNG (5)

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

III. EMPATHETIC CONFRONTATION

EMPATHETIC CONFRONTATION

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

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

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

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EMPATHETIC CONFRONTATION (1)

the therapist expresses his or her understanding

why the client has this schema,

and the difficulty of changing it.

while simultaneously recognizing the need for change

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

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EMPATHETIC CONFRONTATION (2)

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

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EMPATHETIC CONFRONTATION- STEP-BY-STEP

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

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

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EMPATHETIC CONFRONTATION - STEP-BY-STEP

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

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

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EMPATHETIC CONFRONTATION - STEP-BY-STEP

3. *Validate the biographic origins of this mode*

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

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EMPATHETIC CONFRONTATION - STEP-BY-STEP

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

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

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EMPATHETIC CONFRONTATION - STEP-BY-STEP

5. *Make a decision*

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

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EMPATHETIC CONFRONTATION - STEP-BY-STEP

6. Change of behavior

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

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EMPATHETIC CONFRONTATION STEP-BY-STEP

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

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EXERCISE: EMPATHETIC CONFRONTATION

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

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

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IV. BEHAVIORAL PATTERN-BREAKING

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THE PATTERN BREAKING I

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

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THE PATTERN BREAKING II

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