The Schema Therapy Clinician's Guide

A Complete Resource for Building and Delivering Individual, Group and Integrated Schema Mode Treatment Programs

Joan M. Farrell • Neele Reiss • Ida A. Shaw



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Illustrations by Britta Finkelmeier

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This edition first published 2014
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Registered Office
John Wiley & Sons, Ltd, The Atrium, Southern Gate, Chichester, West Sussex, PO19 8SQ, UK

Editorial Offices
350 Main Street, Malden, MA 02148-5020, USA
9600 Garsington Road, Oxford, OX4 2DQ, UK
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Library of Congress Cataloging-in-Publication Data

Farrell, Joan M., author.
The schema therapy clinician's guide : a complete resource for building and delivering individual, group and integrated schema mode treatment programs / Joan M. Farrell, Neele Reiss, and Ida A. Shaw.
p. ; cm.
Includes bibliographical references and index.
ISBN 978-1-118-50917-3 (pbk.) – ISBN 978-1-118-50918-0 (cloth)
I. Reiss, Neele, author. II. Shaw, Ida A., author. III. Title.
[DNLM: 1. Psychotherapy–methods–Handbooks. 2. Personality Disorders–therapy–Handbooks. 3. Psychotherapy, Group–methods–Handbooks. WM 34]
RC480.5
616.89′14–dc23
2014002676

A catalogue record for this book is available from the British Library.

Cover image: Alamy, ID C84W3F
Cover design by Design Deluxe

Set in 10.5/13pt MinionPro by SPi Publisher Services, Pondicherry, India

1 2014

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Foreword

I am very pleased to have been invited to write the foreword for this groundbreaking resource, which will allow clinicians to integrate Individual and Group Schema Therapy (GST) sessions into complete treatment programs that can be delivered over a range of patient populations, treatment lengths, and levels of care.

Since I first heard about the extremely positive results of the authors' randomized controlled trial of GST for patients with borderline personality disorder (BPD) in 2008, I have been very excited about the potential of the group model to make Schema Therapy more available and affordable for patients. Given the worsening climate for mental health reimbursement in this era of managed care in the United States and elsewhere in the world, Group Schema Therapy has the potential to deliver the powerful treatment strategies of the schema approach in a more cost-effective manner than has been possible with individual schema therapy – with equivalent or perhaps superior results. I am especially excited about the large-scale clinical trial that is under way at 14 sites in six different countries. Arnoud Arntz and Joan Farrell serve as the co-principal investigators of the study, testing the efficacy and cost-effectiveness of the Group Schema Therapy model for BPD patients combined with two different numbers of individual sessions.

This book, with the collaboration of Neele Reiss, the psychologist and schema therapist who pioneered GST in Germany, extends the integrated Individual and Group Schema Therapy program for use with a wide range of patient groups – personality disorder, complex trauma, chronic difficulties, those who have failed in other treatments, and those who need a higher level of care. It includes the novel concept of giving patients a "bank account" of individual ST sessions to draw on, as they need to; this concept was developed for the BPD multisite trial. Since the publication of the first book on GST (Farrell & Shaw, 2012), there have been many initiatives internationally to apply the GST model to other diagnostic groups of patients. Like individual ST, GST is trans-diagnostic – in the sense that the focus of interventions is the mode profile of the patient rather than specific symptoms. Thus, GST,

like ST, should be effective for disorders other than BPD. Of course, any application needs empirical validation and I am happy to say that preliminary findings are promising. This integrated program has been tested in inpatient and day hospital settings for BPD (Reiss *et al*., 2013a) and mixed Cluster B and C disorders (Muste, 2012; Fuhrhans, 2012). Its use in forensic settings is being evaluated in the UK. A randomized controlled trial comparing ST to cognitive–behavioral therapy (CBT) for avoidant PD and social phobia and an experimental case series for dissociative disorders are under way in the Netherlands.

The integration of Group and Individual Schema Therapy presented here feels entirely consistent with my own individual model, in terms of the conceptual model, therapeutic alliance, and treatment interventions. The GST model encourages group members to become like a healthy family in which they can "re-family" each other, under the watchful guidance of two highly skilled therapist-parents. The sense of belonging and acceptance provided by this group analogue of a loving family seems to catalyze both the limited reparenting and emotion-focused components of ST. Furthermore, by utilizing two co-therapists for each group, GST has found a way to free up one therapist to move fluidly around the group, often working with one or two members at a time, creating novel experiential exercises to bring about change. At the same time, the second therapist serves as the "stable base" for the rest of the group, maintains an ongoing emotional connection with each member, monitors the reactions of all members, explains what is happening to educate them about what is taking place, and intervenes to shift the direction of the group to focus on the needs of other group members. I am also impressed that GST goes well beyond the traditional CBT/DBT (dialectical behavioral therapy) group format, in which members are taught skills in a seminar-like setting; and beyond non-CBT groups, in which the therapist does individual work with one member while the rest of the group primarily watches. In GST, the techniques used in Individual Schema Therapy, like imagery change work and mode role-plays, have been adapted to engage all of the members in unique exercises that make use of the power of group interaction and support. These group therapeutic factors, combined with the broad range of integrative techniques that are already part of ST, may account for the large treatment effects in the controlled outcome study I mentioned earlier, as well as in preliminary data from other ongoing studies of GST.

The authors describe a systematic approach to ST treatment, while retaining the flexibility that I have always valued so highly in developing Individual Schema Therapy. The treatment suggestions are specific and well organized, while avoiding the temptation to write a therapeutic

"cookbook" for therapists to follow in a rote manner. The authors have preserved the core elements of ST by developing "limited reparenting" intervention strategies for each mode that arises, seizing "experiential moments" to do emotion-focused work that brings about change at a deep level. Like individual ST, their group model blends experiential, cognitive, interpersonal, and behavioral work. The program presented here divides ST interventions into four main components: Schema Therapy Education, Mode Awareness, Mode Management, and Experiential Mode Work. There are sessions of each component that target the main schema modes one at a time. The individual and group sessions are coordinated by mode. The individual ST sessions give therapists the option of a cognitive, experiential, or behavioral pattern-breaking intervention. The authors provide specific therapist script examples that allow access for the beginner using ST, yet have the essential flexibility of ST so that they can be adapted to meet an individual patient's mode and need. The combination of structure and flexibility in this manual make it accessible to practitioners at all levels of experience with ST. The book is written at a level that should appeal to a very broad range of mental health professionals, including psychologists, social workers, psychiatrists, counselors, and psychiatric nurses, as well as interns and residents.

The experience that the authors have gained over 30 years of training therapists throughout the world, and of leading GST groups with a broad range of clinical populations, is evident throughout the volume. This book is the first published treatment manual for integrating Individual and Group Schema Therapy, and succeeds in providing the most essential information that clinicians will need in order to develop and implement such programs. The program sessions can be delivered in intensive form for higher levels of care, such as inpatient and day therapy, or spread over a year of outpatient treatment. The program could begin with more sessions per week, then taper in intensity and be moved to outpatient care. The user-friendly format of the book includes patient examples, descriptions of group and individual sessions, and examples of therapist scripts to explain core ST concepts in language easily understood by patients, along with patient handouts, exercises, and assignments. This material is presented in the manual itself as well as being available in downloadable form on the Wiley website for use with patients.

On a more personal level, I had the opportunity to experience GST first hand as a participant at an advanced training workshop that I invited Joan and Ida with Neele to teach for the senior schema therapists at our New York institute. I am even more excited about the potential of ST in a group after this experience, and would love to conduct an ST group like this

myself once I have learned the necessary skills. Joan Farrell is an outstanding schema therapist who serves as the "stable base," emotional center, and "educator" for the group as a whole – a role I can imagine myself learning to fill, given enough time and experience. What truly amazed me – perhaps because her style is so different from mine and Joan's – was the remarkable group work of Ida Shaw. It is hard to convey the level of originality, creativity, and spontaneity she brings to the group experience. She is able to blend elements of gestalt, psychodrama, role-playing, and her own infectious style of play into an approach that perfectly fits the intensive demands of schema mode work, cajoling patients to change in profound ways. The group exercises in this manual will allow schema therapists to try out some of her unique work. Neele Reiss adds the perspective of the "next generation" of schema therapists who are intent upon practicing and empirically validating ST. She collaborated on inpatient studies of the integrated model for BPD patients (Reiss *et al*., 2013a) and her current work applies ST interventions to problems like test phobia and eating disorders.

I highly recommend this outstanding manual to all mental health professionals working with more complex, chronic, and hard-to-treat patient populations – especially those who are looking for an evidence-based, cost-effective alternative to existing therapies. This book is essential reading for professionals interested in schema therapy, BPD and other personality disorders, group therapy, and new approaches to expanding CBT.

Jeffrey Young, PhD
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March 2014

Acknowledgments

This book is the culmination of our collaboration with Neele Reiss that began in 2008 when we discovered at the International Society of Schema Therapy Conference in Portugal that someone else in the world was doing Schema Therapy in groups. We have had hours of discussion, fun, and ice cream since then and the development of an important friendship which we treasure. We thank Arnoud Arntz for his mentorship, personal support, and friendship; Jeff Young for his thought-provoking discussions, support, and encouragement and Wendy Behary for commiserating about the arduous task of writing and for humor at needed moments.

The therapists who trained with us made important contributions to this treatment manual as teaching them forced us to make explicit and clear the way we practice Group Schema Therapy. Most of all we thank our patients, who taught us what we needed to understand about their needs and struggles and what worked to help them.

Special thanks from Joan to Elke and Siegbert Reiss for their warm hospitality, lovely meals, and fine wine during a heavy writing period as well as German history lessons and sightseeing during much needed breaks.

Joan Farrell and Ida Shaw

Writing this book with my close friends Joan and Ida has been a wonderful journey with many new discoveries. I want to thank you for the collaboration and the warm friendship over the past years.

I would also like to thank Friederike Vogel, who has been a very supportive colleague ever since we started working together and has become a dear friend to me. Furthermore I would like to thank all my patients – without them I would never have learned to practice Schema Therapy and Group Schema Therapy.

Last but not least, I would like to thank my family, especially my father Siegbert and my mother Elke, and my best friend Steffi – for your patience, your advice, for grounding me whenever needed, and for your unconditional support at all times. I know I can count on you.

Neele Reiss

About the Companion Web Site

A companion web site is available for this book at:



www.wiley.com/go/farrell

Visit the site to download the patient materials for your personal use.

1

Introduction

This manual presents an integrated Individual and Group Schema Therapy Program that is transdiagnostic, designed to be implemented in a variety of treatment settings and in programs of varied length. It is written for psychotherapists in a practical manner with a clinical focus. Sample therapist scripts, detailed session instructions, and handouts for each individual and group session are provided.

1.1 Background

Schema Therapy (ST), developed originally for individual psychotherapy by Young (1990; Young, Klosko, & Weishaar, 2003), is an approach to the treatment of a wide variety of psychological disorders that integrates cognitive, experiential, or emotion-focused and behavioral pattern-breaking interventions. It is a comprehensive model that strategically integrates aspects of other approaches but remains unique. A group version of ST was developed (Farrell & Shaw, 2012; Reiss & Vogel, 2010; Muste, Weertman, & Claassen, 2009). The effectiveness of individual (IST) and group (GST) therapy for borderline personality disorder (BPD) has been validated empirically (Giesen-Bloo *et al*., 2006; Farrell, Shaw, & Webber, 2009; Reiss, Lieb, Arntz, Shaw, & Farrell, 2013a; Nadort *et al*., 2009). The model of ST is transdiagnostic. The use of ST for avoidant personality disorder (PD), social anxiety, eating disorders, post-traumatic stress disorder, narcissism, anti-social PD, substance abuse, and psychopathy is being explored and evaluated internationally. It is an approach that is rated positively by both patients and therapists (Spinhoven, Giesen-Bloo, van Dyck, Kooiman, & Arntz, 2007). In addition, ST has growing evidence of its cost-effectiveness for the individual modality (IST) (Giesen-Bloo *et al*., 2006; Nadort *et al*., 2009). However, the limited availability of specialized individual psychotherapies,

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including ST, in the current healthcare economy has prevented more wide-scale use of IST in clinical settings. An integrated program combining multiple GST sessions with a limited number of IST sessions in a structured program has been evaluated, with promising results (Muste, Weertman, & Claassen, 2009; Reiss *et al.*, 2013a). Combining more frequent group ST sessions with strategically planned individual sessions has the potential for making this promising treatment more widely available in a larger number of settings.

The concept of an integrated and structured program was originally developed for use with severe patients in hospital settings (Reiss *et al.*, 2013a), but it can be implemented across a wide range of patient populations, treatment settings, and treatment lengths. One patient population for whom it is ideal are those with personality disorders or PD features, those with chronic or complex psychological problems, those with multiple trauma histories, and those for whom other treatment approaches have failed. In general, these are patients who are treated at the higher levels of care and whose life potential is tragically not realized in the quality of their lives. An advantage of Schema Therapy is that it approaches treatment by targeting maladaptive schema modes rather than specific symptoms or disorders, thus transcending psychiatric diagnoses and impending changes in diagnostic classification. This program can be implemented in inpatient, day therapy, and intensive outpatient settings, as well as in general outpatient treatment with varying session frequency. A program of intensive sessions as the beginning of outpatient treatment may act to "jump-start" the treatment of patients with entrenched maladaptive coping strategies that produce the severe and sometimes life-threatening symptoms of disorders like BPD. It is possible to use all the handouts provided throughout this book within the context of individual ST treatment or selectively within other psychotherapy models. For example, the experiential interventions can augment cognitive therapy, filling a gap in that approach to treating patients with personality disorders and complex trauma.

The program of the manual is theoretically consistent with individual ST (Young *et al.*, 2003) and group ST (Farrell & Shaw, 2012). Like most approaches to psychotherapy that go beyond skills training, ST requires specialized training to meet adherence and competence standards. This manual was designed to make IST, GST, and their integrated combination accessible for a wide range of psychotherapists of multiple theoretical orientations, including those working in intensive settings like inpatient and day therapy programs. The manual provides a detailed step-by-step guide for an ST fundamentals program that integrates IST and GST sessions. The program includes the core components of ST: limited reparenting,

education about the ST model, mode awareness, mode management and cognitive, experiential, and behavioral pattern-breaking change work. It can be used across diagnostic groups. There are 12 individual sessions and 42 group sessions. Each session is described in terms of goals, therapist interventions, tips on management, sample session scripts for therapists to adapt, and corresponding information handouts, ST exercises, and therapy assignments. The individual sessions are designed to be complementary to the group work and the schema mode being focused on, while still allowing individual needs to be met. How to balance individual and group focus is discussed throughout. This level of detail will allow therapists new to Schema Therapy to conduct sessions with confidence and to coordinate group work effectively with individual work. It will also allow more experienced individual schema therapists to begin leading ST groups effectively. The program is not a rigid protocol, but rather a framework combining flexibility with standardization. The structured yet flexible format serves a number of purposes: the manual can be used as a detailed plan for implementing a structured, integrated program of individual and group ST in higher levels of care settings with multiple sessions per week; as a research protocol for psychotherapy outcome studies; or clinicians can select individual or group sessions, or the combination, to work on specific schema modes. Therapists can choose whether to implement the program as a whole, or to select individual sessions, group sessions, or a combination of both to suit their group and its needs.

1.2 The Chapters

Chapter 2 presents the basic concepts of the ST model originally developed for individuals by Young (Young *et al.*, 2003) and the adaptation for groups developed by Farrell and Shaw (2012). The goals of ST, the therapist approach of limited reparenting, and the core components of the model are described in this chapter. The approach of the integrated ST program to combining individual and group sessions is discussed. The general course and stages of the treatment program are outlined here. Chapter 3 describes some of the essentials of the treatment program: the patients, with inclusion and exclusion factors; the therapists; the milieu – both the physical setting and the multidisciplinary treatment team; the length of sessions and treatment; and the possible schedules and format for delivering the program in different settings. Chapter 4 presents the group sessions by component, with sample therapist scripts and the patient materials – handouts, group exercises, and session assignments. Chapter 5 presents the 12 individual sessions – with specific content, sample scripts, and handouts. Chapter 6

describes the ST training and supervision recommended for therapists. The research that has been conducted is summarized, with a brief description of the investigations that are in progress at the time of writing.

This book is unique in the ST literature as its goal is to provide an implementable program in its entirety. It is not focused on a particular disorder. It is not limited to one of the modalities of treatment delivery; it covers both individual and group ST. The reader is referred to the ST volumes in the References for theory and focus on specific disorders.

2

The Basics of Schema Therapy

2.1 The Theoretical Model

The model presented in this manual is consistent with the theory, components of treatment, and goals presented by Young, Klosko, and Weishaar (2003). The Schema Therapy (ST) model is summarized here and the reader is referred to that volume for additional elaboration of the individual ST model and its application. ST grew out of efforts by Young *et al.* (2003) to treat patients with personality disorders more effectively, and also those who either did not respond to traditional cognitive therapy or relapsed. ST is based upon a unifying theory and a structured and systematic approach. Because ST is an integrative treatment, there is overlap with other psychotherapy models such as cognitive and psychodynamic psychotherapy, object relations theory, and Gestalt psychotherapy, but total overlap with no other model.

Figure 2.1 summarizes the model for the etiology of psychopathology posited by ST. When the normal, healthy developmental needs of childhood are not met, maladaptive schemas develop. Maladaptive schemas are psychological constructs that include beliefs we have about ourselves, the world, and other people, which result from interactions of unmet core childhood needs, innate temperament, and early environment. ST views this interaction in terms of a plasticity or differential susceptibility model. Schemas are comprised of memories, bodily sensations, emotions, and cognitions that originate in childhood and are elaborated through a person's lifetime. These schemas often have an adaptive role in childhood (e.g., in terms of survival in an abusive situation – it engenders more hope for children if they believe they are defective as opposed to the adult being defective). By adulthood, maladaptive schemas are inaccurate, dysfunctional, and limiting, although strongly held and frequently not in the person's conscious awareness. Young (1990; Young *et al.*, 2003) identified 18 early maladaptive schemas

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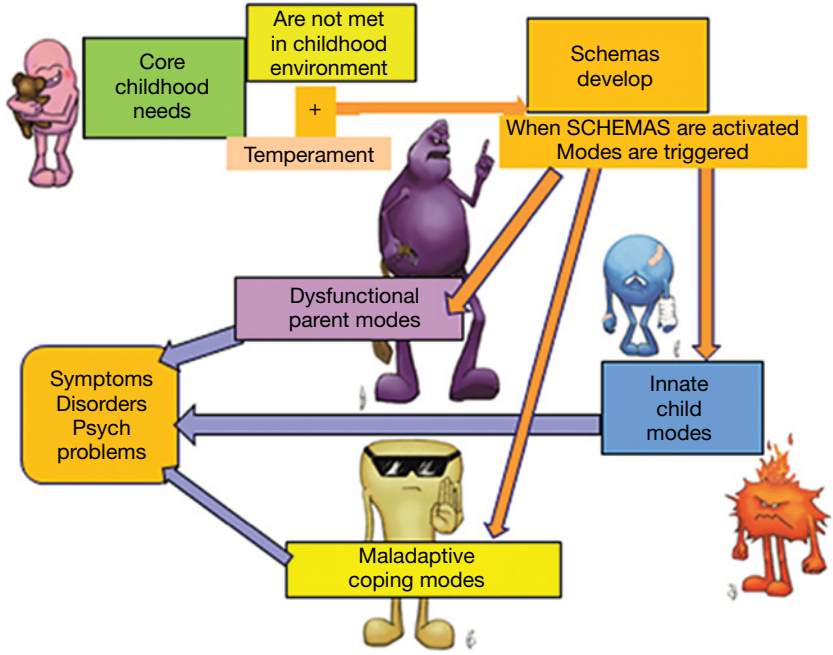


Figure 2.1 Schema Therapy: Etiology of psychological disorders.

Table 2.1 Schemas organized by content area

Disconnection and rejection	*Impaired autonomy and performance*
Mistrust/Abuse	Dependence/Incompetence
Emotional Deprivation	Vulnerability to Harm/Illness
Defectiveness/Shame	Enmeshment/Undeveloped Self
Social Isolation/Alienation	Abandonment/Instability
Emotional Inhibition	Subjugation
	Failure
Impaired limits	*Exaggerated expectations*
Entitlement	Self-Sacrifice
Insufficient Self-Control	Unrelenting Standards
Other	
Negativity/Pessimism	Approval-Seeking/Recognition-Seeking
Punitiveness	

Table 2.2 Basic schema modes

Innate Child Modes	Vulnerable Child Angry/Impulsive Child	Innate responses to unmet needs
Maladaptive Coping Modes	Avoidant Protector Overcompensator Compliant Surrenderer	Overused survival responses to trauma or unmet needs – flight, fight, and freeze
Dysfunctional Parent Modes	Punitive Parent Demanding Parent	Selective internalization of negative aspects of early others
Healthy Modes	Happy Child Healthy Adult	Underdeveloped

(EMS) in patients with personality disorders (Table 2.1). The schemas are defined individually in the patient materials for the ST Education group (ST-Education Sessions 1–5).

When maladaptive schemas are activated, intense states occur, described in ST as "schema modes." A schema mode is defined as the current emotional, cognitive, and behavioral state that a person is in. Dysfunctional modes occur most frequently when multiple maladaptive schemas are activated. Four basic categories of modes are defined (Table 2.2).

Primary or innate child modes (Vulnerable Child, Angry Child, Impulsive Child) are said to develop when basic emotional needs in childhood (such as safety, nurturance, or autonomy) are not adequately met. These "child modes" are defined by intense feelings such as fear, helplessness, or rage, and involve the innate reactions a child has. Dysfunctional Parent Modes (Punitive Parent or Demanding Parent) comprise the second category of modes. Dysfunctional Parent Modes reflect the selective internalization of negative aspects of attachment figures (e.g., parents, teachers, peers, etc.) during childhood and adolescence. Maladaptive Coping Modes, a third category of mode, are defined by an overuse of unhealthy coping styles (fight – overcompensation; flight – avoidance; or freeze – surrender). All have the goal of protecting the person from experiencing pain, anxiety, or fear. These Maladaptive Coping Modes operate outside of conscious awareness and a goal of ST is that patients become aware of their coping styles and learn healthier, more adaptive coping responses. Maladaptive Coping Modes incorporate the concept of defense mechanisms, a concept previously missing in cognitive therapy, and allow for a better understanding of personality disorders by clinicians and patients. The overcompensating coping style contains modes in which a person acts in opposition to the

schema or schemas that are triggered. One example is the Bully-Attack Mode in which the person experiencing the pain resulting from a schema retaliates by causing pain. The avoidant coping style involves physical, psychological, and social withdrawal and avoidance. Avoidant Modes include the Detached Protector, a mode that ranges from a person being "spacey," or briefly losing focus in an interaction, to severe dissociation. This mode is very commonly present when patients enter therapy as it operates to protect the Vulnerable Child Mode from overwhelming fear or painful feelings. Surrender is the third coping style and it represents giving in or giving up to the schema present. For example, if the triggering schema is defectiveness, a surrender response would be to accept that you are defective and behave accordingly: never taking on challenges, working not to be exposed as incompetent.

In a fourth category, Healthy and Functional Modes, the Healthy Adult Mode and Happy Child Mode are found. The Healthy Adult Mode includes functional thoughts and behaviors, and the skills needed to function in adult life. The Happy Child Mode is a resource for playful and enjoyable activities, especially in social networks. Many patients were neither allowed nor encouraged to play, thus missing opportunities to explore their likes and dislikes and take part in our earliest social interactions with peers. The healthy modes tend to be severely underdeveloped in patients with personality disorders or features.

Modes are often triggered by events that patients experience as highly emotional. Modes can switch rapidly in patients suffering from severe personality disorders, resulting in the sudden changes in behavior or seemingly disproportionate reactions that are one source of patients' interpersonal difficulties and emotional and behavioral instability. Modes can also stay rigidly entrenched, as is the case with many avoidant patients. Common negative coping responses – aggression, hostility, manipulation, exploitation, dominance, recognition-seeking, stimulation-seeking, impulsivity, substance abuse, compliance, dependence, excessive self-reliance, compulsivity, inhibition, psychological withdrawal, social isolation, and situational and emotional avoidance – can be understood in mode terms.

Symptoms of personality disorder can be described and understood in terms of the operation of modes. One example is the ST conceptualization of borderline personality disorder (BPD). Abandonment fears describe the emotional state of the Vulnerable Child Mode. Intense anger, at times accompanied by uncontrolled expressions of anger, occurs in the Angry Child and Impulsive Child Modes. The Impulsive Child Mode fuels action that is potentially damaging as well as being one source of self-injurious behavior. The Dysfunctional Parent Modes are another source of self-injurious

behavior, to fulfill their dictate that the child deserves punishment or is a failure. The parent modes can also be a source of suicide attempts as they remove all hope and their judgments condemn the patient to misery and feelings of worthlessness. The Detached Protector Coping Mode can be a cause of self-injurious behavior, particularly cutting or burning the skin in order to feel something. The Detached Protector Mode explains the experience of emptiness, which can be intolerable and can lead to suicide attempts. If you are detached from your feelings, a central part of who you are, your identity will not be stable. Mode-flipping accounts for some of the emotional reactivity seen in BPD patients and consequently their unstable relationships.

Other personality disorders and psychological problems can just as easily be described in mode terms, providing user-friendly, understandable language for patients and the foci for psychotherapeutic intervention for therapists. Mode language focuses more on the role of learning and less on psychopathology, giving patients hope regarding change.

2.2 Goals and Stages of Schema Therapy

Young *et al.* (2003) summarizes the primary goals of treatment as helping patients change dysfunctional life patterns and get their core needs met in an adaptive manner outside of therapy, *by changing schemas and modes*. The goals of ST reach beyond teaching behavioral skills to include the fundamental work of personality change. This change is conceptualized as involving decreasing the intensity of maladaptive schemas that trigger under- or over-modulated emotion and action states referred to as modes. The triggering of these intense states is seen as interfering with patients' use of adaptive coping or interpersonal skills that would allow them to realize their potential and improve their quality of life. In terms of each type of mode, the goals can be elaborated as:

To develop the Healthy Adult Mode so that the patient is able to:

1. Care for the Vulnerable Child Mode. Healthy adult competence is accessible when fear, sadness, or loneliness, which reflect unmet childhood needs, is triggered.
2. Reassure and replace the Maladaptive Coping Modes. For example, be able to experience emotions when they arise, connect with others, and express your needs. Coping choices that meet the person's need and the reality of the adult situation he/she is in are made, rather than defaulting to Maladaptive Coping Modes like avoidance.

3. Replace the behavior of the Angry/Impulsive Child Mode with appropriate and effective ways to express emotions and needs; e.g., the ability to express needs in an assertive adult manner and anger in a healthy way.
4. Overthrow and banish the Punitive Parent. Get rid of the harsh internalized critic, replacing it with the ability to: motivate oneself in a healthy positive manner; accept one's mistakes and, when needed, make retribution for them. Moderate the Demanding Parent Mode to have realistic expectations and standards.

We add a fifth goal:

5. Free the Happy Child Mode so that the patient can explore the environment to learn about what gives him/her joy in life and can play.

ST approaches these goals in stages. The **stages** and the **goals** of each stage can be summarized as:

1. Bonding and emotional regulation:
   - healing the Vulnerable Child;
   - bypassing the Maladaptive Coping Modes;
   - affect regulation and coping skills.
2. Schema mode change:
   - combating the Punitive Parent and Demanding Parent Modes;
   - rechanneling the Angry and Impulsive Child;
   - setting limits;
   - handling crises.
3. Autonomy:
   - individuation: following natural inclinations;
   - developing healthy relationships;
   - gradual termination with the option of contact.

2.3 Limited Reparenting

Limited reparenting is both a therapist style and an active ingredient or component of mode-change work. Limited reparenting is defined as: acting as a good parent would in meeting child mode needs within the bounds of an appropriate therapy relationship. This means providing protection, validation, and comfort for the Vulnerable Child Mode; the opportunity to vent and be heard for the Angry Child; and empathic confrontation and limit setting for the Impulsive Child Mode. Limited reparenting is one of

the core components of ST and a hypothesized active ingredient. Limited reparenting is often referred to as the "heart of ST."

The behaviors of the schema therapist can be summed up as "doing what a good parent would." Early in treatment, strong parenting is needed as patients are frequently in child modes and have an underdeveloped Healthy Adult Mode. Later on, there is more Healthy Adult presence and the therapist's role changes to being the "parent" of adolescents and then eventually of adults. In this later phase, patients still need the therapist to maintain connection, but are able to do some parenting of themselves and each other. The language, sophistication, and use of specific ST techniques must be adapted to the developmental level, comorbid disorders, and psychological health of the group members (i.e., some techniques and terminology that may be helpful with BPD patients may not be acceptable to narcissistic personality disorder patients, etc.). When working with the Vulnerable Child Mode, we sound like parents talking to a young, frightened child. When confronted with Maladaptive Coping Modes we can become almost as firm as a drill sergeant (while at the same time not losing touch with letting the patient know that we empathize with the feelings and needs underneath the mode).

The goal of limited reparenting is to establish an active, supportive, and genuine relationship with the patient that provides a safe environment for the patient to be vulnerable and to express emotions and needs. The therapist's provision of limited reparenting within the psychotherapy relationship allows the patient to fill in critical early gaps in emotional learning via secure attachment and accurate mirroring that lead to experiencing feeling valued and worthy, often for the first time. Initially, the therapist tries to compensate for the deficits in the patient's emotional needs being met within the limits of appropriate professional boundaries. Some of the unmet childhood needs include: safety, consistency, validation, appropriate boundaries, and healthy limits. Over time, the experience of the therapy relationship fosters patients learning to care for their own needs in an effective manner and eventually to attain autonomy and healthy interpersonal functioning. This approach to needs is in sharp contrast to most other models, which focus too early on patients meeting their own needs. ST assesses the strength of patients' Healthy Adult Mode and attempts to fill gaps in early emotional learning about needs through an initial phase in which therapists meet needs directly, providing new positive experiences directly. The new experiences, interactions, and implicit attitudes that make up the process of meeting core emotional needs become the building blocks for the Healthy Adult Mode. Table 2.3 describes the relationship among the mode a patient is in, the unmet childhood need involved, and the therapist intervention required.

Table 2.3 Suggested therapist interventions in relationship to patient modes and needs

Schema mode	*Unmet childhood needs*	*Therapist intervention* *Limited reparenting*
Vulnerable Child Experiences intense feelings of sadness, loneliness, anxiety. Emotional pain and fear can become overwhelming and lead to flips into the Maladaptive Coping Modes.	Secure attachment (includes safety, predictability, stable base, love, nurturance, attention, acceptance, praise, empathy, guidance, protection, validation).	Meet the listed needs, comfort, soothe, reassure, wrap in blanket, connect with vulnerable child (VC) in a concrete way to match developmental level, listen, reassure fears, soft tones.
Angry Child Vents anger directly in response to perceived unmet core needs or unfair treatment. Can take the form of a young child's tantrum.	Guidance, validation of feelings and needs, realistic limits and self-control. Freedom to express, validation of needs and emotions.	Listen, emotional expression, support venting, guide them into safe anger expression (e.g., tug-of-war), set limits for safety or to prevent negative consequences. Help them identify unmet need they are responding to, understand that they may have difficulty thinking while very angry.
Impulsive/Undisciplined Child Impulsively acts based on immediate desires for pleasure, without regard to limits or others' needs (not related to core needs).	Realistic limits and self-control, validation of feelings and needs, guidance.	Set gentle yet firm limits, guide, teach healthy release exercises. Help them identify the need that is present.
Happy Child – underdeveloped Feels loved, connected, content, satisfied.	Spontaneity and play. Nurturance, attention, validation, acceptance, encouragement to explore and play.	Take pleasure in them and their playfulness and show this visually, smiles, laughter, invite them to play, play with them.

Punitive Parent Restricts, criticizes, and punishes self and others. Harsh, rejecting, all or none in judgments.	The Dysfunctional Parent Modes suppress and reject the needs of the child. This can apply to any need – particularly love, nurturance, praise, acceptance, guidance, validation, emotional expression.	Stop the Punitive Parent Mode (PPM) message, set limits on and eventually banish this mode. Support and connect with the VC needs.
Demanding Parent Sets high expectations and level of responsibility for self and sometimes others, pressures self or others to achieve them.		Challenge the message, reassess what reasonable standards and expectations are. Support and connect with VC needs.
Avoidant Protector Pushes others away, breaks connections, emotional withdrawal, isolates, avoids.	Any unmet childhood need can produce one of these Maladaptive Coping Modes, thus any need can underlie them. They are versions of the survival responses of flight, fight, and freeze and are overused and automatic.	Identify underlying need, for VC it is connection, encourage emotional thawing. If Angry Protector form, set limits and try to connect through it.
Overcompensator Coping style of counterattack and control. Sometimes semi-adaptive.	The immediate need is connection and empathic confrontation. Long-term need is to learn healthy coping that fits better with adult life. That is the goal of therapy and requires developing the Healthy Adult Mode (HAM).	Help patient identify underlying need and evaluate whether the overcompensating style is meeting it. Connect patient with his/her Vulnerable Child Mode (VCM). Limit damage to group.

(*Continued*)

Table 2.3 (*Continued*)

Schema mode	*Unmet childhood needs*	*Therapist intervention* *Limited reparenting*
Compliant Surrenderer Surrenders to the schema, acts as if it is true. For example: is self-sacrificing, gives up own needs for others. If defectiveness shame, accepts self as failure and does not try.	The Maladaptive Coping Modes need to be reserved for extreme emergencies.	Identify unmet need, evaluate whether coping mode meets it, help get need met. Connect with VCM.
Health Adult – underdeveloped Meets a person's needs in a healthy and adult manner, fulfills the requirements of adult life, is able to enjoy life's pleasures, and forms and maintains healthy relationships.	Acknowledgment and support of autonomy, competence, sense of identity. Lack of childhood needs being met leads to underdevelopment of Healthy Adult Mode (HAM). The more unmet needs, the less HAM development.	Invite the use of competence in GST, create opportunities to use and recognize strengths and point them out with accurate positive feedback. Acknowledge and allow autonomy.

Some adaptations of limited reparenting are necessary when conducting group ST. These include the need to focus on and balance the collective need of the group as a parent would for a group of siblings. Group reparenting may be a closer approximation to patients' developmental experience, unless they were only children. This closer match with the early environment has the potential to provide additional, or strengthening of, schema healing experiences. In group, needs are met by both the therapist and the group. GST offers additional opportunities for emotional learning and socialization from these interactions with "sibling" group members and from the experience of belonging to a group "family." Two of the first and primary tasks of the schema therapist, whether working in IST or GST, are establishing connection and safety. In both modalities this comes from the therapist communicating validation, acceptance, liking, that you care and they matter, that you are trustworthy, reliable, and consistent. In the group it is also a therapist task to facilitate connections between and among patients, facilitating their bonding with each other and helping them develop a sense of belonging in the group. Belonging comes initially from discovering that they share the experience of some common problems and feelings, along with the common childhood experience of some unmet childhood needs. Over time, belonging can expand as they share emotional experiences in the group and develop shared memories. In intensive settings with multiple weekly group meetings, we emphasize the aspects of the group that are like a family. These "re-family" effects intensify the limited reparenting of ST.

The forms of attachment in each modality – bonding in IST and belonging in GST – both require safety. Safety and trust require consistency, openness, and reliability. In the group, establishing firm ground rules regarding the way patients treat each other, physical boundaries, respect, and commitment, and enforcing them, is crucial. Therapists need to tell patients in the group that they will keep them safe, and behavior must be consistent with this promise. This means managing conflict and stopping negative attacks, including those that are mode driven (e.g., Bully-Attack Mode behavior). It is important to manage conflict in early sessions until the group has the strength to deal with it in a healthy manner and resolve differences or misunderstandings. The group is an excellent place for patients to learn conflict resolution and relationship management with therapist guidance. It is also a task of the therapist to structure sessions. In both modalities this means keeping in mind the goal of the mode being worked with and minimizing distractions. In the group, distraction is defined as something said or a topic brought up that has little to do with where the rest of the group is, but does not constitute a mode reaction.

As a "good parent," the group schema therapist enforces limits for the good of all, and attempts to treat all patients as equal and in a manner perceived as fair.

The model for GST is also integrative. It combines aspects of the other forms of group therapy strategically and always with direction from the therapist(s) as "good parents." Table 2.4 summarizes the main models of group therapy and their integration into GST.

In GST sessions it is important to use the group therapeutic factors – universality, belonging, altruism, existential factors, corrective recapitulation of the family, vicarious learning, in-vivo learning, expanded information sources – in the service of ST goals and techniques. A summary instruction regarding therapist tasks could be: "Do *Group* Schema Therapy, not just Individual Schema Therapy in a group." Ideally, the switch from individual to group ST requires both using the potential of the group for any individual work and making the individual work that occurs relevant for all. The group therapists must be able to focus the group for work with a specific individual and then broaden the focus to include all group members. This requires making some personal contact with other members while the major focus is on an individual. This can be done primarily by the second therapist, but also by the therapist leading the work or by a solo therapist. The two-therapist model developed for GST is described further in Chapter 4 and thoroughly in Farrell and Shaw (2012).

A group presents therapists with both opportunities and challenges not present in IST. This chapter first gives an overview of group therapist behaviors that are necessary to develop and maintain the therapeutic frame needed to conduct ST in a group. Integral to the GST model is the therapist focus on using the tremendous value of the group by facilitating its therapeutic factors. The frame of GST is established by the ground rules (see Welcome Group Handout 1: GST Ground Rules, in Section 3.6). Therapists must model a strong, consistent, affirming, and supportive presence for each patient and the strength to reparent the group. Part of the foundation of ST is secure attachment, and achieving the reliable connection this requires in a group is best done by two therapists. The ideal number of therapists is a function of the developmental level of the group members. With BPD patients, we are dealing with people stuck at childhood developmental levels with early emotional learning deficits (e.g., lack of secure attachment, deficits in emotional awareness). With forensic patients, two therapists are needed to maintain safety and the ground rules as well as empathically confronting and setting limits on the overcompensating modes that frequently occur in this group. Two therapists for avoidant patients help keep anyone from "falling through the cracks" and getting lost

Table 2.4 Models of group therapy

Model	*Examples*	*Goals*	*Therapist role*	*Use of each model in GST*
Interaction or Process Group	Interpersonal groups Psychoanalytic groups Encounter groups	Change problematic behaviors using group dynamics. High emotions and conflict are desired.	Outside of group Stimulates interaction, but does not guide it All can start interaction at any time.	Uses group dynamics as a source of change (group curative factors). Therapist is part of group and actively leads and directs members.
Person-Oriented Group	Gestalt Cognitive therapy Psychodrama Problem-solving therapy	Work on individual needs and goals.	Focus on and support the protagonist. Foster instrumental group conditions. Structure the session. Members aid protagonist in their goal.	Work is done on individual needs and goals, but always linked back to the commonalities among members. Members aid in individual work and join in the work. Attention to group process is prioritized over instrumental conditions. Aid among members is mutual.
Psychoeducational or Disorder-Specific Group	Manualized group therapy for specific disorders: (e.g., depression, anxiety, BPD)	Knowledge and skills Empowerment (expert on own illness)	Teaching information Teaching skills Structure the session. Guide the group. Focus on the "middle patient."	Psychoeducation and guidance are provided in child modes. Rather than a "middle patient" – attention to all patients' needs and goals is balanced. Experiential work is prioritized over skills.

(*Continued*)

Table 2.4 (*Continued*)

Model	*Examples*	*Goals*	*Therapist role*	*Use of each model in GST*
Group Schema Therapy Combines aspects of all three with total overlap with none.	GST (Farrell, Shaw, & Webber, 2009; Farrell & Shaw, 2012)	Schema mode change that allows changes in dysfunctional life patterns and allows getting core needs met in an adaptive manner	Conduct the group in a manner that harnesses group process and curative factors. Act as a good parent, matching group's developmental level. Encourage group members' participation in reparenting.	All of the above are aspects of GST; however, *they are strategically directed by the therapist*(s) as "good parents."

Source: Farrell, J. & Shaw, I. (2012). *Group Schema Therapy for borderline personality disorder: A step-by-step treatment manual with patient workbook*. Chichester: Wiley Blackwell.

in the group. If only one therapist is possible in a setting, it will be helpful to increase the amount of structure (e.g., homework review, working together on assignments, more use of written exercises). If a choice must be made as to which of the group components to use two therapists in, we suggest the Experiential Mode Work sessions.

We define two different therapist roles that are either assumed alternately by the group therapists, or, in the situation where one is more experienced in ST or group, the two roles may be divided based upon difficulty level. They are:

1. the therapist who leads the work;
2. the therapist who maintains connection with all patients and monitors the needs of the group members not immediately involved in the work of the moment.

Connection is maintained by therapist 2 in part by making eye contact in a directed manner around the group. The eye contact, when returned, can be followed by a nod or little smile, some nonverbal acknowledgment. Even when patients do not make eye contact, they report that they are aware of being checked on and that this is reassuring. Therapist 2 may also move to sit closer to a patient in distress without stopping the work that therapist 1 is leading. Therapist 2 may give the patient in distress a piece of soothing fleece, a shawl, or another comfort object kept in the group room. The therapist in role 2 is every bit as important as role 1. Therapist role 2 includes stopping the action at times if individual focus has gone on too long and the rest of the group is detaching or the tension level in the group needs to be reduced. The therapist 2 intervention may be as simple as stopping everything and saying to therapist 1: "We need to stop for a moment and check in with the rest of the group. Everyone just take a nice, deep breath and shake out your shoulders." This is followed by a brief check-in and regrouping before going back to the work or changing direction somewhat to better meet the needs of more of the group. The "dance" of the two group therapists is described extensively in Farrell and Shaw (2012) and demonstrated in a DVD series of Farrell and Shaw leading a group of patients with BPD (played by schema therapists) (Zarbock, Rahn, Farrell, & Shaw, 2011). As a beginning co-therapist team it is helpful to plan ahead of time who will take what role in terms of material to present, leading an exercise, and so forth. Over time, it becomes second nature for one therapist to move to role 2 when the other is in role 1. Therapists must keep in mind that a goal of GST is that every patient have some defined role in experiential exercises; no one is left just watching. It may be the role of an assigned observer who has a

specific monitoring task, or if someone is in some distress the task for them may be taking care of themselves by taking a seat out of the action wrapped in a shawl, but no one is left out.

2.4 The Components of Schema Therapy

One of the unique aspects of ST is its strategic integration of experiential, cognitive, and behavioral pattern-breaking interventions to accomplish the goals of the model. We speculate that the large treatment-effect sizes that ST demonstrates for BPD patients are due, in part, to this integrative approach which facilitates deeper-level and long-lasting personality change (Giesen-Bloo *et al.*, 2006; Farrell, Shaw, & Webber, 2009). ST is the only truly integrative approach to personality disorder treatment. Other approaches are weighted toward cognitive, behavioral, or experiential interventions to the neglect of the other components. Inclusion of all three components is necessary to maintain the integrity of the ST model.

3

The Integrated Schema Therapy Treatment Program

The integrated Individual and Group ST program described here was designed to meet the needs of a range of treatment settings and lengths. In intensive settings, such as inpatient and day hospitals and intensive outpatient settings (IOPs), group and individual sessions are commonly combined. Having a structured ST program with coordinated contents and materials for both modalities makes the best use of these settings and facilitates therapy progress. Uncontrolled pilot trials on an all-BPD inpatient units demonstrated significant treatment effects for intensive ST programs, which combined the individual and the group modality (Reiss, Lieb, Arntz, Shaw, & Farrell, 2013a). Whether Group Schema Therapy (GST) delivered in a massed format in inpatient or in day therapy, or over a year in traditional outpatient psychotherapy, is more effective in terms of clinical outcome and cost-effectiveness is a research question yet to be determined. As with most treatment, the answer is likely to be determined in large part by the patients being treated.

The individual and group formats can be seen as having a reciprocal relationship. Educating the group members on the topic of early maladaptive schemas and schema modes takes place primarily in the group setting. Individual therapy provides the therapist and patient an opportunity to expound on these topics and how they relate to the person's individual process. This deeper understanding can then serve to move the group process forward. As individual group members become familiar with how the modes operate in their own experience they are then able to bring this understanding to their peers. This sharing is often more powerful than the examples the therapists can provide.

Table 3.1 presents the integrated ST program by session.

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Table 3.1 Integrated Schema Therapy Program by session: group and individual

	Group sessions		*Individual sessions*	
Screening and preparation for treatment	WELCOME GROUP Ground rules, orientation to program, connection exercise, safety bubble	ST EDUCATION GROUP 5 sessions – Schema Therapy model, language, goals, problems in ST terms	Screening, inclusion/exclusion Assessment Commitment to program	Session of orientation to ST as it applies to the individual patient. Forms that translate patient problems or symptoms into ST model. Discuss SMI results.
	Group sessions		*Individual sessions*	
Treatment component	**Mode Awareness**	**Mode Management**	**Experiential Mode Work**	**First 6 sessions**
Mode of focus	Recognize your experience of the modes and learn to identify their presence.	Cognitive and behavioral strategies to manage modes; develop a personal Mode Management Plan (MMP).	Corrective emotional experiences related to mode, childhood need, imagery rescripting, mode role-plays.	ST conceptualization, individual patient program goals. Apply group work to the individual. Support group participation.
MCM	Recognize your experience of the MCM and your coping style, understand connection to childhood experience.	Develop immediate healthy strategies to reduce the strength and frequency of the MCM. Part of the Emergency Mode Management Plan (MMP).	Experiential focusing exercise, role-play to demonstrate MCM functions and evaluate their current effectiveness, safe-place image, work on group cohesion and connections.	SMI results, discuss origins and triggers of modes, ID MCM behaviors, behavioral experiments, personal Pro and Con list for MCM, cognitive distortions, mode dialogue, agreement with MCM to allow HAM to take charge sometimes.

PP/DePM	Recognize which Dysfunctional Parent Mode and see as "not you"	Develop immediate strategies to stop PPM or DePM messages. Part of Emergency MMP.	Construct group effigy of PPM/DePM. "Punishment experiment." Good Parent Message Script, introduce transitional objects.	Historical role-play, work with effigy, mode dialogue, positive schedule, identity circle, cognitive distortions, mode flashcards, imagery rescripting.
VCM	Recognize presence of the mode, the feelings involved, foster compassion for the VC.	Develop an immediate plan of healthy strategies to respond to VCM needs when sad or anxious feelings are present. Emergency MMP.	Therapist rescripting example, check on Good Parent Message Script use, imagery rescripting either individual or group as a whole, memories of needing GP, transitional objects.	Soothing VCM activities, limited reparenting, identify likes and fears of VCM, needs and rights of children, imagery rescripting, flashcard for VCM.
A/ICM	Recognize mode in operation, able to identify underlying need.	Develop an immediate MMP to safely release anger and limit maladaptive action from A/ICM. Part of the Emergency MMP.	Physical anger work. Fun with anger, team anger-release game, construct ACM image.	Mode role-play, ACM flashcard, reaction of others to ACM work, needs of ACM, healthy attention to venting anger, identify need underlying ACM, mode dialogue ACM with other modes.
HCM	Evoke HCM, identify modes that interfere with access to HCM.	Develop a short-term MMP for strengthening of the HCM.	Imagery to evoke the HCM.	Identify ways to evoke the HCM, play in session, identify HCM likes, give HCM positive feedback, "indulgence training," imagery to evoke HCM.

(*Continued*)

Table 3.1 (*Continued*)

	Group sessions		*Individual sessions*	
HAM	Recognize HAM and use skills to work on goals with other modes. Begin a review of first 6 sessions of treatment.	Develop a short-term MMP to access HAM and strengthen the mode. Continue review with focus on MMP plan.	Mode role-play to experience being in HAM directing the maladaptive modes, bead transitional object with group and therapist feedback.	Begin to construct HAM, present with a bead for identity bracelet, behavioral experiments using HAM skills, identify role of HAM in future healthy life.
	Second round of groups – same mode sequence			*Sessions 7–12*
MCM	Aware of HAM point of view and skills, use awareness to replace old coping mode with more effective strategies to meet needs	Develop a long-term MMP to reduce triggering of MCM and increase use of HAM skills to meet needs.	Connection exercise to reduce MCMs. Mode role-play focus on HAM directing the maladaptive modes. Empathic confrontation of MCM.	Continue work from sessions 1–6, use interventions from IST-MCM, support awareness of MCM and ability to make a healthier coping choice.
PPM	Increase awareness of and access to HAM in order to banish PPM, moderate DePM.	Develop a long-term MMP to banish PPM and moderate DePM.	Work with PPM-DePM messages using effigy symbols, Post-It notes/"you should have said." Replace with Good Parent messages, exercises to banish PPM.	Work with remaining IST-DyPM material, more work to banish PPM, and strengthen Good Parent representation.
VCM	Increase awareness of and access to HAM in order to comfort or reassure the VCM.	Develop a long-term MMP to meet VCM needs related to sadness and anxiety and to heal the VCM.	Child on street imagery – first with stranger, then self, rescripting group as whole.	Work with remaining IST-VCM material, imagery rescripting with a higher difficulty level if needed (i.e., trauma work)

A/ICM	Increase access to HAM for adaptive action to meet needs and set healthy limits on A/ICM-driven action.	Develop a long-term MMP to reduce disruption from A/ICM and express anger assertively.	More anger-release work – balloons, whichever exercises not used in previous AC session. Mode role-play – focus on ACM dialogue with modes.	Work with remaining IST-ACM material, assess ability to meet needs with assertiveness
HCM	Increase awareness of modes that interfere with HCM and access to HAM to facilitate HCM coming out to play.	Develop a long-term MMP for strengthening of access to the HCM.	Creative fun exercises, imagery to ban DyPM modes, HCM imagery work, practice evoking HCM outside of therapy sessions.	Work with remaining IST-HCM material, playful in session, look at transfer of play outside of therapy sessions.
HAM	Develop plan for HAM to use awareness to meet needs in an adaptive way. Wrap-up of what has been learned about self in mode awareness work.	Develop a long-term MMP for strengthening the HAM that will continue to be used to continue ST work after treatment.	Mode role-play to experience being in the HAM. "Identity bracelet" exercise with group and therapist feedback about current state of HAM. Graduation from the program exercise.	Review and summarize course of treatment, assess progress toward goals with focus on HAM strengths. Plan for how to continue ST work. Therapist gives a transitional object.

It is important to support the value of both modalities and all components of the program. Some patients will prefer individual sessions and others group sessions. In this program the majority of treatment hours involve group sessions, but it is the strategic combination of treatment modalities and the inclusion of all core ST components that work together to accomplish the goals of the treatment program. All members of the treatment team must consistently support this view. Patients may begin the program having had negative experiences in some other groups and with the idea that individual therapy is "better." Yet, when the whole array of possible new experiences during group treatment and the tremendous benefits that are possible in that modality are explained to patients effectively, they tend to understand the importance of using both modalities. This information can be given to patients during their assessment for the ST program when they are informed about the program and its requirements.

3.1 The Patients: Who Are Good Candidates?

As previously stated, ST can be implemented with a wide range of patient populations, including the most challenging. For this program:

- **Inclusion criteria are:** patients with personality disorders or features, complex trauma, or chronic problems that have not responded to other treatments and who are motivated to participate in GST and able to commit to the length of treatment.
- **Exclusion criteria are:** patients with lifetime Axis I psychotic diagnoses (it is important to not exclude based upon the transient psychotic episodes of severe BPD, which are sometimes misdiagnosed), ADHD meeting childhood criteria with symptoms uncontrolled by pharmacotherapy, inability to speak or read the language the group will be conducted in, or an IQ below 80.

We use this IQ cut-off based on our experience of patients below this level becoming frustrated by difficulties in keeping up with the group material. These difficulties often are perceived as unacceptable differences and consequently they activate defectiveness and failure schemas in such a manner that it is difficult to help those patients. A homogeneous group with lower-IQ patients is a possibility that has not yet been evaluated. When we began all-BPD patient groups in 1989, many of our colleagues questioned our judgment. Over 20 years later, we have the data to support our innovation.

3.2 The Group Schema Therapy Sessions

The Group Schema Therapy model of the program is consistent theoretically with the model and theory of ST as developed by Young (Farrell, Young, & Shaw, 2011). The goals and therapist approach are the same and ST interventions are adapted to delivery in a group. GST is thoroughly presented in the treatment manual by Farrell and Shaw (2012). The group sessions of this treatment program are described individually in Chapter 4. Detailed therapist notes sections including sample scripts for sessions are provided, as well as patient materials (handouts, exercises, and therapy assignments) for each session. The manual is set up to accommodate the reader by placing handouts and therapy assignments following their description in the text. The patient handouts and assignments are also provided for your use in downloadable form on the companion web site at www.wiley.com/go/farrell.

GST follows the stages of IST described in Section 2.2, but these stages are affected by the naturally occurring stages of therapy groups. These are: bonding and cohesiveness; conflict; establishing norms and the working group (Yalom & Leszcz, 2005). In GST, therapists actively encourage the positive aspects of each stage. The group therapist must be active in facilitating the bonding and working stages of the group and set limits on, and re-channel, conflict. Limit setting and empathic confrontation ensure that the inevitable conflict that arises leads to healing and growth. The autonomy stage in ST takes place as the Healthy Adult Mode develops and becomes stronger. The working group stage is facilitated by patients having some access to the Healthy Adult Mode. Early in this stage, therapists often must lead, or lend patients some of their Healthy Adult Mode. Later on, it is important for therapists to step back and allow patients to try out their Healthy Adult skills. Obviously, individual groups will plot their own course through these stages. In addition, the stages are not linear. Groups return to the bonding or conflict stages at times, particularly in response to challenging events in the group or difficult life events.

The group itself is an important source of interpersonal learning, offering many opportunities for modeling and vicarious learning. Our patients frequently tell us that it took watching an Angry Child Mode tantrum in a peer for them to truly understand the effect of that behavior on others and to be motivated to change. The ST group functions as a supportive family and is often the first time a patient has experienced this. The experience of acceptance in the group has tremendous therapeutic value at the emotional level for the Vulnerable Child Mode. Group is a place to practice forming and maintaining healthier relationships, explore boundaries, develop

communication skills, and learn how to negotiate and resolve conflict when needs are at odds. Because the impairment of personality disorders has such a large interpersonal component, one might argue that a setting rich in interpersonal interactions is especially well suited to providing the required corrective emotional experiences.

For the purpose of matching the needs of intensive programs for multiple weekly group sessions with therapists having different training and strengths, we have developed four types of ST group session. Each focuses primarily on one or two of the ST components and, when combined, they cover the basic experiential, cognitive, and behavioral ST interventions. The four sets of group sessions are: Education about the ST model, Mode Awareness, Mode Management, and Experiential Mode Work. What follows is a brief description of the group sessions and the ST components covered in them.

3.2.1 The "Welcome" session

We start group treatment with a session, as the name indicates, in which the goal is to make patients feel welcome and convey that they are important members of our group. All therapists of the treatment team attend this session so that they can be introduced and give patients the opportunity to ask questions. We orient patients to the program and its ground rules (Welcome Group Handout 1: GST Ground Rules (WEL 1)) and discuss what to expect in group sessions. We do an introduction to imagery exercise, the first safety exercise (Welcome Group Handout 2: The Bubble-Safety Technique (WEL 2)), and an experiential exercise that facilitates connection (see Section 4.2 and Therapist Instructions – Welcome Group: The Group Identity Bracelet (WEL-TI).

3.2.2 Schema Therapy Education sessions

Schema Therapy begins with education about the Schema Therapy model and how it is used to explain psychological problems and their treatment. This provides a shared user-friendly language in which the therapists and patients can communicate. Providing this information is empowering and facilitates collaboration. There are five ST Education sessions, each 50–60 minutes long. Schema Therapy Education patient handouts are provided, labeled ST-ED1 to ST-ED5.

3.2.3 Mode Awareness sessions

This component has the goal of patients understanding their mode experiences and being able to identify the trigger situations, the modes, and the underlying

need. Describing the different components of modes, such as cognitive or physiological components, can help patients become aware of the mode they are in. Connecting the current situation to childhood memories allows them to understand the roots of their schemas and modes. Only after patients are aware of the mode they are currently in can they make a conscious decision whether or not to stay in this mode or to access and use Healthy Adult Mode skills. There are 12 Mode Awareness sessions, each 50–60 minutes long. Mode Awareness patient handouts by mode are labeled MA-1 to MA-12. Therapist instructions for each session can be found in Section 4.4.

3.2.4 Mode Management sessions

Awareness is the first necessary, but not sufficient, step in the process of mode change. Next comes cognitive work to evaluate with patients the effectiveness of mode-dominated responses in getting needs met and to form and evaluate alternate action plans, referred to as Mode Management Plans. Cognitive, behavioral, and experiential techniques are the main interventions employed in developing and using Mode Management Plans. In this component, any barriers to change – beliefs or actions that maintain maladaptive mode behavior – are identified and worked through. One example of this work is correction of cognitive distortions that maintain schemas and modes. The application of Mode Management Plans developed in these groups provides the needed behavioral pattern-breaking work which ensures that therapeutic changes generalize to behavior outside of the therapy setting. There are 12 group sessions for this component, each 90 minutes in length. Mode Management handouts by mode are provided, labeled MM-1 to MM-12. Therapist instructions for each session can be found in Section 4.5.

3.2.5 Experiential Mode Work sessions

Experiential Mode Work includes visual imagery, imagery rescripting, mode dialogues, mode role-plays (an ST intervention similar to psychodrama), and creative work to symbolize positive experiences. To change modes at the emotional level we develop "experiential antidotes" with patients. We are often told by patients: "I *know* in my head that I am not defective or abandoned, but I *feel* defective and abandoned." This statement summarizes the need to target the emotional level of modes in order to effect deeper-level change. *Knowing* that one is not defective or a failure does not eliminate *feeling* that one is defective and a failure. Feelings like these (implicit knowledge), with their accompanying shame, self-hatred, and fears of

rejection, are what keep patients miserable, unhappy, and functioning below their abilities even when they have learned cognitive and behavioral skills. Imagery rescripting and experiences of belonging and acceptance in a group that serves as an analogue of the primary family combine to provide multiple corrective emotional learning experiences. Creative and symbolizing work in the Experiential Work Mode sessions includes using art or written material that can facilitate recall and the emotional re-experiencing of schema-contradicting events. Experiential Mode Work handouts by mode are provided labeled EMW-1 to EMW-12. Therapist Instructions for these sessions can be found with them in the text of Section 4.6.

3.3 The Individual Schema Therapy (IST) Sessions

The 12 individual sessions of the program, like Young's IST, integrate and include cognitive, experiential, and behavioral pattern-breaking sessions over their course. The ratio of 12 individual sessions to 42 group sessions reflects both the particular effectiveness of the group ST modality in impacting maladaptive modes and the relative availability of the two modalities in the current mental healthcare systems of most countries. This is particularly true in inpatient, day therapy, and intensive outpatient settings. In the integrated program, individual sessions are used to take the work done in group further in terms of individual application. This means assisting patients in understanding their specific symptoms and psychological problems in ST terms, working on their versions of the maladaptive, dysfunctional, and healthy modes, and developing an ST case conceptualization to use as a plan for their treatment. Some patients with severe trauma histories feel a need to share more of those experiences than is possible in GST. Although the ST approach to trauma is not to encourage re-experiencing, but rather to rewrite endings of traumatic experiences using imagery rescripting, there are times when patients have never shared their abuse and feel a need to start there. Some patients will feel more comfortable doing imagery rescripting in individual sessions and sometimes there will not have been time in group to get to everyone. Individual sessions can ensure that all patients are able to do some rescripting work. They also provide an opportunity to get help in understanding education material or applying it to oneself or to go over assignments in more detail than is possible in group. Some group assignments are referred to individual sessions for further discussion. Individual sessions can also be used to ensure that patients understand the group work, are able to apply it to themselves, and are doing the group assignments in between sessions. An example of the two

modalities working together occurs with the goal of building the Healthy Adult Mode. We first learn about ourselves from the reactions of others and the labels they apply to us. The group is a good place to receive healthy feedback and to have early misinformation corrected. Feedback and new positive labels from peers can be powerfully challenging to maladaptive schemas like defectiveness/shame and failure. This feedback and related group corrective emotional experiences can be further processed and anchored into a more positive sense of identity in individual sessions. Patient handouts and assignments by mode are described in Chapter 5 and provided in reproduceable form on the web site www.wiley.com/go/farrell. They are labeled IST followed by a mode abbreviation and session number.

There are two main approaches to the use of the 12 individual sessions:

1. Spacing the individual sessions across the period of treatment, whether it be 12 weeks or 12 months. The sessions can be spaced evenly over the period of treatment or they can be more frequent at the beginning of the period and then less frequent as time goes on and patients engage firmly in the group "family."
2. Giving patients a "bank account" of 12 sessions and allowing them to decide when they make withdrawals from their accounts. These withdrawals can be made in 15–50-minute segments.

Table 3.2 presents the goals, foci, and patient materials for each component of ST treatment.

3.4 Options for the Delivery of the Treatment Program

A number of time frames are in use for both IST and GST. The original randomized controlled trial (Farrell, Shaw, & Webber, 2009) evaluated the effectiveness of 30 sessions of 90-minute weekly groups over a period of eight months when added to 20 months of individual psychotherapy that was not ST. Thus, the total treatment length was close to two years, with eight months of that period including ST. The clinical trial of individual ST evaluated three years of twice-weekly, and then weekly, individual sessions. Pilot studies from inpatient settings evaluated programs of approximately 120 hours of group and 12–18 hours of individual ST over three months. The treatment effect sizes were high in all of these lengths and formats. These studies are described in Chapter 6. The full program described in this manual consists of 42 sessions of GST (54 hours) and 12 hours of IST. The 90-minute group sessions can have a 10-minute break if needed to ensure that all remain alert.

Table 3.2 Treatment components, goals and focus, patient materials list

Component	*Goals and focus*
The Welcome Group 1 session, 50–60 minutes	Experience being welcomed and valued. Meet the therapists (treatment team in some settings). First connections with their group of peers and the therapists. Understand the program ground rules. Understand what to expect to experience in early group sessions.
Schema Therapy Education (ST-ED) 5 sessions, 50–60 minutes	Understand ST basic concepts and model. Learn the ST language. Understand the role of unmet core childhood needs and modes in their psychological problems. Understand the goals of the program.
Mode Awareness Group (MA) 12 sessions, 50–60 minutes	Understand their experience of the Innate Child, Maladaptive Coping, Dysfunctional Parent, and Healthy Modes. Be able to identify the presence of these modes. Identify the triggers of modes and the needs underlying the modes. Monitor their daily mode activity.
Mode Management Group (MM) 12 sessions, 90 minutes	Develop cognitive, behavioral, and experiential strategies and techniques to manage modes and healthy action to meet the underlying needs. Formulate Mode Management Plans and practice their use. Sessions 1–6 focus on more immediate, short-term mode management and 7–12 on long-term mode management.
Experiential Mode Work Group (EMW) 12 sessions, 90 minutes	The experiential mode-change work of ST. Imagery, including imagery rescripting, mode role-plays, therapist-led corrective emotional experiences. The experience of belonging and acceptance in a close analogue to the family. Expansion of limited reparenting to relationships with other group members. Most of the EMW sessions do not have assignments. They do have extended therapist instructions and sample scripts.

Table 3.2 (*Continued*)

Component	*Goals and focus*
Individual Schema Therapy (IST) 12 sessions 50–60 minutes	ST Conceptualization, Treatment Goals form and Mode-Problem-Treatment Plan Summary are complete in individual sessions. Focus on limited reparenting, safety, bonding. Individual ST conceptualization. More experiential, cognitive and behavioral mode change work of ST. More detailed work on how material from group sessions applies to the individual. Additional imagery rescripting of trauma or mode issues. Patient's ability to share and connect in the group. Discussion of missed sessions or disruptive to group behavior. Crises that are not group related, for example, finances, housing. Most of the individual sessions with experiential exercises do not use handouts.

The program can be delivered in a wide variety of formats to meet the structure of intensive inpatient treatment, day therapy programs, intensive outpatient programs, or general outpatient programs, with one or two sessions a week. Table 3.3 shows what some of these options would look like.

Although the effectiveness of using components of the full program alone or the individual sessions independent of the group sessions has not been evaluated, these are also options. In an early pilot we attempted to provide group sessions without any individual sessions for patients with BPD in an outpatient community mental health center. This was not found to be adequate to meet patient needs and consequently we added "bank accounts" of individual sessions that patients could draw from over a defined time period. If this seems like a lot of treatment, one has only to look at the epidemiological data on mental health services when patients are not given planned treatment (Comtois *et al.*, 2003). One must also keep in mind that ST is an approach with the goal of recovery, not just symptom control. GST, with its growing evidence base, has the potential to be cost-effective and widely available. This would help to solve the problem of the demand for BPD treatment exceeding the supply of evidence-based options, particularly in public mental health settings.

Table 3.3 Formats and lengths for the Integrated Schema Therapy treatment program

Format	*Hours*	*Weeks*	*Welcome session 5 ST Education*	*12 Mode Awareness*	*12 Mode Management*	*12 Experiential Mode Work*	*12 Individual Schema Therapy*
Inpatient	10	6	All 6 sessions in week one	2 sessions per week	2 sessions per week	2 sessions per week	2 per week
Inpatient	5	12					
Day therapy	5	12	All 6 sessions in week one	1 of 4 sessions per week	1 of 4 sessions per week	1 of 4 sessions per week	1 of 4 sessions per week
Intensive outpatient	5	12					
Day therapy	2.5	26	Welcome, STEd 1–2 wk 1	Session 1 of 2 in weeks 3, 5, 7, 9, 11, 13, 15, 17, 19, 21, 13, 15	Session 2 of 2 in weeks 3, 5, 7, 9, 11, 13, 15, 17, 19, 21, 13, 15	Session 1 of 2 in weeks 4, 6, 8, 10, 12, 14, 16, 18, 20, 22, 24, 26	Session 2 of 2 in weeks 4, 6, 8, 10, 12, 14, 16, 18, 20, 22, 24, 26
Twice weekly outpatient	2.5	26	STEd 3–5, wk 2				
Weekly outpatient	1.5	52	Welcome, STEd 1 – wk 1 STEd 2–3 – wk 2 STEd 4–5 – wk 3	Weeks 5, 9, 13, 17, 21, 25, 29, 33, 37, 41, 45, 49	Weeks 6, 10, 14, 18, 22, 26, 30, 34, 38, 42, 46,50	Weeks 7, 11, 15, 19, 23, 27, 31, 35, 39, 43, 47, 51	Weeks 4, 8, 12, 16, 20, 24, 28, 32, 36, 40, 44, 48, 52

The full program consists of 42 GST sessions and 12 IST sessions. These can be condensed into a program as short as 6 weeks inpatient or day therapy or extended for over a year of outpatient treatment.

Overall, we think that using the full 42 group sessions and 12 individual sessions of the program is optimal, but realize that it may not be possible for all settings. Some inpatient settings may have only four or six weeks and in that case the first six weeks of this program could be implemented. We want to stress, however, that the four components of mode change presented here, combined with limited reparenting, are the minimum necessary components to meet adherence criteria for a program to be described as ST.

3.5 Structural Aspects of the Group Sessions

We suggest eight patients as the ideal group size with two therapists. Ten to twelve is possible with very experienced group therapists. With one therapist it is better to have six patients. This being said, we have been in situations with twelve patients and one therapist. The developmental level of the group, the strength of patients' Healthy Adult Mode, and the composition of the group make more difference than number alone. Again, the practical demands of clinical settings often determine number. In our pilot studies (Reiss *et al.*, 2013a), owing to a budget cut we had the opportunity to compare our treatment effect size for groups of 11 BPD inpatients with one versus two group therapists. Although improvement was still significant and matched the result of other approaches to BPD treatment, it was much lower than our result with a two-therapist pair.

Most general healthcare settings, in contrast to research settings, are not able to run totally closed groups in which all group members begin and end a 12-week program at the same time. For that reason, this manual is arranged with the option of two program admission points, six weeks apart, which can be used to stagger admissions. To facilitate these planned additions of new patients, the program has two cycles of six weeks. Groups may be open or closed depending upon your setting and whether you are conducting a research study or clinical practice. When conducting a trial, we have closed groups. In clinical practice, groups are usually open. There are pros and cons to each approach and we can only speculate about differential effectiveness since we have no comparative studies to guide us. One advantage of a closed group is that all patients are learning the material at the same time and have a longer period of time in the same group, hopefully facilitating cohesiveness. A 12-week closed group can more easily build upon itself. Sometimes newer patients felt "left out" when group experiences from the preceding six weeks were shared, or compared themselves negatively to the senior members and had defectiveness schemas

activated. Staggered admissions also require some use of group time to answer questions from new patients that senior patients already understand. However, we have also observed treatment benefits in open groups when the patients admitted at time 1, who after six weeks are familiar with the program, are given the task of being "big sister or brother" or "mentor" to the newly admitted patients. The "senior" patients have opportunities for experiences of competence that can contribute to positive changes in schemas of defectiveness and failure. Many patients have told us that being a mentor was the first time they experienced feeling that they had value or were competent. The newly admitted patients can have the healing experience for their Vulnerable Child Mode of a supportive older sibling and having their need for acceptance and connection met.

Planned additions to ongoing open groups are suggested. When adding patients, it is preferable to add at least two at a time to give newcomers a "buddy" for support in the entry process. In the event of early drop-out, it is possible to add replacement patients within the first four weeks of the group's existence. It can be difficult in inpatient settings to admit eight patients at the same time. One solution is to add four at a time, so you have equal numbers of new and senior patients.

3.6 Assessment and Orientation

As part of their assessment for the program, patients have one or two individual meetings with a member of the treatment team. In these meetings they are evaluated for inclusion using the criteria for the particular program and setting. They will have completed the short Schema Mode Inventory (SMI; Lobbestael, van Vreeswijk, Spinhoven, Schouten, & Arntz, 2010; Reiss *et al.*, 2012) and are asked to bring the SMI to this meeting(s). These inventories help define ST treatment goals and are used as outcome measures for the program. We also test motivation and the ability to commit to the treatment period in terms of psychological and practical issues. We want to make sure that they do not anticipate a move out of the area or a change of job or lifestyle (marriage, birth of a child) that would interrupt their participation. Unforeseen events occur in life, but we have found it important to inquire about those that can be anticipated. We make clear the seriousness of the commitment they are making to the group and that we are making to them, and describe

the negative effects on a group when people leave prematurely. About 80% of the patients we screen decide to join a group. In the first outpatient study we did, we had zero drop-outs over the 14 months of the study (Farrell *et al.*, 2009). In inpatient pilots of the integrated program there was over 90% retention (Reiss *et al.*, 2013a).

As part of preparing patients for ST treatment we briefly go over their SMI results and discuss why the program, including the group component, is being recommended for them. We need to have enough information about them to be able to describe what we think the benefits of group will be for them specifically. We want to have the opportunity to give them the information they need to make an informed commitment to the group based upon this information. We inquire about any previous experience with therapy groups, good or bad, and describe what the Schema Therapy group is like and why it is likely to be a different experience. Many patients, particularly those with BPD, can give a number of examples of negative group experiences they have had in other group therapies. We want to instill hope about GST, so we describe how it has helped people with similar problems, the promising results of ongoing research, and our own experiences. We sometimes give them the press release about ST outcome research which is available on the International Society Schema Therapy web site (www.isstonline.com/). We validate their concerns, discuss any fears they have, and try to give reassurance. We describe some of the struggles that patients often have early in a group owing to Maladaptive Coping and Dysfunctional Parent Modes and let them know that we will work with those issues in the group. Warning them about these feelings and that they pass over time helps them to understand their meaning if they occur. It also decreases the likelihood that they will overreact to normal early struggles by leaving the program, particularly the group component. We discuss their hopes about the group and tell them about the high approval rating we have from other patients and the very large positive effects from research. We go over the unique advantages of group treatment and invite discussion to accomplish "buy-in." If we are videotaping sessions, we explain the purposes (i.e., research, training, therapist review, their review) and obtain written consent. This session functions as an anticipatory socialization for ST treatment.

What follows is an example of the way we address common issues like early discomfort and avoidance.

Sample Therapist Script

Group therapy is different from individual and there are some initial adjustments that the whole group needs to make. We need to get to know each other, figure out how we are going to work with each other, and deal with the uncomfortable feelings we all may have during this process. If your early experiences with groups, for example, family, school, or neighborhood, have been difficult, you could have the impulse, if the group at first feels difficult, too, to leave it. This kind of avoidance as a way to cope with uncomfortable emotions is actually one of the maladaptive coping responses that we will be working on in the group because it keeps you stuck. So, if you have that reaction and bring it up in the group, we can talk about it and find healthy ways for you to feel more comfortable. What we just described is one of the important opportunities that a group offers. With time and the help of the therapists, people come to feel that they have understanding, emotional support, and a sense of belonging that they want and never had before. It is this kind of belonging that can fill some of the emptiness that you may experience. So, the group can become a kind of healthy family in which the child parts of you, which did not have their normal, healthy needs met growing up, can have these needs for validation, acceptance, liking, and so forth met and the little child in you can heal.

We explain that it takes about six sessions to begin to feel comfortable in any group and we stress the importance of not making a decision to leave during that period. We describe the attendance requirements of the program here also. Outpatients are required to call a designated person if they are unable to attend a session. If they do not call in, they will be called. This calling is handled primarily by the group members. The roles of being the person who takes calls and who calls members who miss a session are rotated monthly among the patients.

If a group member is not following the attendance guidelines, it should be discussed with him/her in the group (or if the problem is non-attendance, it may be discussed without him/her). The group is given input into how this is handled. Empathic confrontation first, followed by limit setting if necessary, is recommended. Of course, all of these responses need to consider the reason for absences. A member who is hospitalized, ill, or

taking care of a sick relative or friend, for example, should receive a different response than a member who says "I forgot," "I didn't feel like coming," or "I went to a movie instead." The first set of reasons is acceptable, although the issues of self-sacrifice, healthy boundaries, and the need to care for oneself could be explored in the example of caring for others. In the case of the patient who "forgets," it could be due to overwhelming stress and, at first, the group could offer to help with reminder calls. "Not wanting to come" needs to be explored and "going to a movie instead" empathically confronted. A technique that can be used to communicate to an absent member that he/she is important to the group, and that his/her absence affects the group, is to have everyone write a very brief note communicating this information. These notes are placed on the absent member's chair when he/she returns. Whether due to healthy remorse over an absence (e.g., the case of the patient who wanted to sleep in that day) or reassurance for an avoidant patient, this strategy does decrease absences.

Outpatients are informed that if they miss 2–3 sessions in a row and they are not reachable by phone or responding, a letter is sent emphasizing the need to contact. All group members sign this letter along with the therapists. If there is no response to this contact, a letter will be sent telling them that they are no longer in the program and they will need to reapply if they want treatment in the future. Inpatients are told that they are expected to attend all sessions unless they are physically ill and excused from a session. If they miss 2–3 sessions in a row, the same process of discussion and recommitment is employed. In this case they may meet with the treatment team to discuss their attendance problem. They can also be dropped from the program for lack of compliance. In some settings this means that they would remain hospitalized but be transferred to another treatment program in the hospital.

We give patients a copy of the group ground rules in the first orientation session, suggesting that they read them over and come back to the final session with any questions. The ground rules are referred to in the Welcome group as well. We tell patients that these are the guidelines for safety and an effective working group that we have worked out over the years with our patients. We tell them that they have worked for most groups, but if there is something in them unrelated to safety that their particular group wants to change, we are happy to discuss it. An example of our ground rules follows and is available in the patient material as Welcome Group Handout 1: GST Ground Rules (WEL 1).

Welcome Group Handout 1: GST Ground Rules

The goals of the group sessions include:

- providing you with a new way to understand the psychological problems you have and how you can recover from them;
- how to make changes in your life to function better, be happier and more fulfilled;
- helping you to increase your feeling of emotional stability, your comfort level, and your ability to tolerate distress without acting in ways that are harmful to you.

These are ambitious goals that will take time and a good deal of effort on your part. This program will help you learn about and understand your feelings, needs, and thoughts; the impact of childhood experiences on the present; and provide you with healthy coping skills to try out in the safe and supportive environment of the group.

The ground rules for the group are not meant to be a lot of red tape, but to help make the group a safe and supportive environment for everyone. They were developed over years with consultation from many groups of patients like you. We have ground rules so that everyone will know what to expect and what is expected of them, members and therapists. If problems with them come up, they can be discussed at any time in the group. If there is something that does not fit for this group, we will discuss how to change it as long as safety is not compromised. We want them to work for this group.

1. Attendance

Members are expected to attend all sessions and be on time. Groups over the years decided that if people are more than 10 minutes late without an emergency reason or something outside of their control (for example, delayed in traffic due to an accident or construction), they cannot join while the group is in progress. They will need to wait until after the break to join. Only holidays, planned vacations, emergencies, or unforeseen conflicts are considered sufficient reason to miss a group session. If an emergency arises, please call in to inform us so that the group does not worry about your safety.

2. Your Responsibility as a Group Member

Part of your responsibility as a group member is to try. The exercises have been developed to help you learn about your emotions and modes and come to feel that you have some control over them. Members are expected to try to take care of themselves in the session. This means that if the group is doing an exercise that you feel you cannot do yet, you will take responsibility not to do it. There will usually be an assignment suggested to go along with most sessions. These assignments are set up to help you apply things learned in the group to your life situations outside the group. Part of "trying" is that members are expected to try their best to do the group and individual assignments and, if for some reason you are not able to, to let us know what interfered so that we can help you with it.

3. Respect for Other Members

Members are expected to respect other members' physical and emotional space. This means that no one will touch another member without permission and if a member does not want to answer any question, this will be respected. Yelling at others, calling them names, throwing things, and threatening physical harm are obvious examples of unacceptable disrespect that will not be allowed. On the emotional level, this means only asking questions of another member that you yourself would be willing to answer and accepting a response of "I don't feel comfortable answering that question right now." It is also important to be gentle with others when they are in the Vulnerable Child Mode. We realize that you may be struggling with controlling anger and verbal outbursts, so the therapists will help you get these behaviors under control if they happen in the group. You will not be "kicked out" for having symptoms. You will be asked, however, to take a time out in the group's safe area or outside the group room in order to get a problem behavior under control.

4. The Role of the Group Therapists

All members need to know that the therapists will maintain safety and set limits. At times, this will mean reminding you of the ground rules and asking you to stop a behavior that breaks them. In that way the therapist and patient roles in group are different. The

group therapists in Schema Therapy have the role of acting like good parents. This means different things depending on the mode that a group member is in. If you are in the Vulnerable Child Mode (VCM), a "Good Parent" will find out what you need and, within the limits of the therapy relationship, try to meet the need or help you get the need met. For example, a person in VCM will often express feeling scared or hurt. The therapists can provide protection, reassurance, comfort, or soothing. If you are in the Angry or Impulsive Child Modes, which we see as innate child reactions to needs not being met, a "Good Parent" or therapist will set limits – as that is one need in that mode. The Angry Child also needs to be heard, sometimes to vent angry feelings. Venting is different from attacking others. Sometimes venting can be too disruptive to take place in the group. In that case, one of the therapists may leave with a patient for a short time and return after venting has been accomplished. An Impulsive Child may need to be stopped from taking actions that will damage him/her or their relationships. Coping Modes can also be triggered in group. If a member is using avoidant coping – missing group, leaving group when upset, spacing out, or not paying attention, the therapists will confront this by pointing it out in an empathetic way. The same is true of the Surrender Mode. The therapists will point this out and help the person examine whether that action really meets their needs in adult life. The Overcompensating Modes like Bully-Attack are the modes that therapists need to respond to with the firmest limits. These modes cannot go without challenge as they can damage the group environment and are the modes that get people in the most trouble out in the world. They can even lead to jail sentences, losing all friends or family by "burning your bridges." When the therapists are acting as "Good Parents," patients can have a number of different reactions, some based upon their relationships with their real parents in childhood. Sometimes the therapists will hook schemas or modes leading to old unhealthy coping behavior. When this happens, it provides important opportunities for the patient to learn about what triggers them and how to access their Healthy Adult Mode to express their need.

5. Confidentiality

Confidentiality is expected of all members for the privacy and safety of all concerned. Whatever comes up in the group that is of a personal nature about another member cannot be repeated outside

the group except with your individual psychotherapist. Please do not fill a peer in on what happened in a group that he/she missed. The therapists have that responsibility when it is needed. The actual exercises and skills learned in the group may be shared with others.

6. Medication/Leaving the Group

◯ Please try not to take sedating PRN medications before the group. *Please do not leave the group except for real emergencies*. Take care of toileting before the group so that you can stay for the hour. If you do have to leave, let the group know what is going on with as little disruption as possible. People leaving has a disruptive effect on the group. People often fear that a person is leaving because of something they said. It can feel disrespectful if people leave for non-emergency reasons.

7. Your Commitment to the Group

You are asked to consider seriously your commitment to the Schema Therapy program. Group therapy can be frustrating at times and you may have strong feelings or reactions to other members. You are one of only eight people accepted in this program at any given time. This integration program has limited availability. We are asking you for a major commitment to stay in the group and we are making a big investment in you in terms of time and resources. You may have had

◯ to wait quite a while for a space in this program. Know that others are waiting for their turn. We ask you to take the responsibility to use this opportunity to get the specialized treatment that is being offered to you. You are here because those who referred you believe that you can be significantly helped here and the Schema Therapy program team agrees. We feel certain that this program can be of benefit to you if you complete it.

(These written rules are given to patients.)

3.7 The Milieu of the Treatment Program

3.7.1 Multidisciplinary teams in intensive settings

To help patients feel safe in an inpatient or day care setting, where many people of different professions work together and some staff work shifts or have substitute coverage, it is helpful to have a photo book with pictures of

each treatment team member and a short description (i.e., "My name is … I work as a …," along with other pieces of information that would ordinarily be shared with patients).

Treatment teams usually have members from different professions and educational backgrounds which can lead to different and sometimes conflicting ideas about how to interact with and approach patients. This can at times cause conflict, but can also provide patients with opportunities to try out their new skills with different people with different backgrounds and practice resolving conflict in a healthy way. However, when implementing an ST with a treatment team, it is essential that the ST approach of limited reparenting be adhered to. It would, for example, be very difficult for patients to understand why one therapist of the treatment team gives them a soothing object when they are in a Vulnerable Child Mode and another one gives them a behavior analysis and sends them to their room to complete it. Without training in ST, some staff members misunderstand limited reparenting, thinking that it is "spoiling" patients, being too lax, and so forth. It is important that the psychotherapists clarify that limited reparenting must match the mode the patient is in at the time. If in Vulnerable Child Mode, soothing, protection, reassurance, validation, and so on are needed, but Angry or Impulsive Child Mode requires firm guidance and limit setting. Consistency is a childhood need which many of our patients did not experience and it is an important requirement in a therapeutic environment. Slight variations in therapists' behaviors and between therapists are to be expected, but all treatment team members must have the same general goals (see Section 2.2) and follow the ST treatment model.

It is critical for all members of the treatment team involved in the program to have read this manual. In inpatient settings, aspects of the limited reparenting environment may seem like a paradigm shift to some members of the multidisciplinary staff. Understanding the reasons for these changes facilitates consistency from all team members. We have attempted to describe very completely the ST content for each session of this program, including sample therapist scripts. Other helpful ST literature includes: Young, Klosko, and Weishaar (2003), Farrell and Shaw (2012), and Arntz and Jacob (2012). Of course, ST supervision is extremely helpful the first time therapists are implementing the program. We describe in Chapter 6 the training and supervision in ST that we recommend for therapists.

We explain to patients the individual and group therapists' availability outside of sessions and regular office hours. We suggest that you follow the general policy of your practice or clinical setting for availability, as long as you give patients in outpatient settings numbers to access emergency services. In inpatient settings there will be staff members present around the clock, but treatment team members are likely to have limited availability.

Often patients, especially those with BPD, are unhappy about having limited access to you. We express concern about their well-being and make sure that they know how to access emergency resources. We also explain the reality of our limitations and the need for a balanced life. Our position on availability is informed by the Nadort *et al.* study (2009), which compared effectiveness of ST with therapist telephone availability versus a plan like the one described here. The study found no significant differences between the two conditions. We also establish safety plans for patients with life-threatening crises early in treatment. This begins to give them some responsibility for identifying their potential safety issues within various mode experiences. For the Vulnerable Child Mode in patients we use transitional objects, voice recordings, notes, and so on to help them feel our presence at times of difficulty and when there will be a gap in sessions for holidays.

3.7.2 The physical environment

Environmental variables can affect treatment and we should attend to them. One important environmental variable to look at for therapists working with the ST model is the décor of the room in which therapy is conducted. Patients should feel welcome and comfortable in the therapy room. To create a limited reparenting atmosphere, warm, indirect light and comfortable chairs are suggested. While this is often provided for in private practice, therapists working in inpatient or day care settings often have to give special attention to making the therapy rooms look non-institutional. For ST groups it is crucial to have a room big enough to allow for movement, which is often required for the experiential exercises. Ideally, there are two therapists for each group. In groups, chairs can be arranged in a circle, with the therapists ideally sitting across from one another. This helps therapists notice each other's signals more easily. Keep in mind, though, that when a patient is in distress or an experiential exercise requires it, therapists switch chairs and it may not always be possible to sit exactly across. It is more important to meet the patients' need than formal requirements like sitting across from one another. If you are a single therapist in a group, switch your position regularly, so that different patients are able to sit next to you.

Patients are encouraged to bring to therapy things that make them feel safe. To give them an idea of what these things could be, therapy rooms should be equipped with pillows, blankets, stuffed animals, pictures, posters, books, and other items that could be used for soothing and a sense of security. Feeling comfortable will help patients overcome their Maladaptive Coping Modes. In inpatient or day care settings it is helpful to let patients decorate their personal rooms and therapy rooms with posters, creative work, and personal items. If creative or occupational therapists are part of the treatment team, this can be

Table 3.4 Schema therapist tool kit

All Purpose	**Angry/Impulsive Child**
• Whiteboard or flip chart • Paper • Pens, pencils • Construction paper • Magazines – collages • Paints, brushes • Tape recorder and tapes • Ring binders for handouts • Index cards • Stress balls • Clay, play-doh • Ball of yarn • Paint color sample strips	• Towels for tug-of-war • face cloths to tie up and pitch at objects • Clay, play-doh • Stress balls • Larger balls to bounce against walls • Tennis racket to hit a mattress or couch • Balloons to blow up and pop • Bubble wrap to stomp on • Phone books to tear up (in the USA these tend to be a few inches thick, but a smaller one would do)
Vulnerable Child	**Happy Child**
• Blankets • Shawls • Stuffed animals • Kleenex • Children's books • Music – soothing • Beads, stringing for bracelets	• Crayons, colored pencils • Coloring books • Puzzles • Puppets • Playing cards • Games • Balloons • Happy music to dance to

The suggestions by mode are meant to provide ideas, not to limit using any tool for any mode. This is one of the places to be creative!

an opportunity for them to work with patients. It is very helpful to give patients folders to use for organizing their therapy materials. They enjoy having the opportunity to design folders individually and they appreciate access to creative materials for this purpose. Working with patients in this manner is another opportunity for therapists to form connections. In inpatient or day treatment units, staff members have innumerable opportunities to interact with patients and connect to them on different levels. Activities such as baking or organizing a barbecue together, playing a game, or watching a movie together can be therapeutic activities. The total influence of all the daily interactions, shared activities, and treatment components is often more than the sum of its parts.

A variety of materials are needed for the milieu and the experiential component of ST. Table 3.4 gives a list of the things we like to have available. The purpose of some of the items will be clearer after Chapters 4 and 5, which include descriptions of the experiential interventions.

4

The Group Schema Therapy Sessions

The ST program takes one mode at a time, whether this means one mode per week in inpatient programs or a mode every four weeks in weekly outpatient programs. The general sequence in which we focus on the modes is:

1. Maladaptive Coping Modes (**MCM**)
2. Dysfunctional Parent (**DyPM**), Punitive Parent (**PPM**), and Demanding Parent (**DePM**) Modes
3. Vulnerable Child Mode (**VCM**)
4. Angry and/or Impulsive Child Modes (**ACM**, **ICM)**
5. Happy Child Mode (**HCM**)
6. Healthy Adult Mode (**HAM**)

This cycle is repeated twice. In mode categories with more than one major variant (i.e., the MCMs, DyPMs), the therapy materials are designed so that you can choose the mode most prevalent in your patient group. This can be done by spending some session time on each variant or changing the variant in the second cycle. For the VCM it is the main feeling tone that varies –for example, sad, fearful, lonely, abused, and/or a combination are common. Again, the make-up of your group determines your VCM focus. We have combined the ACM and the ICM to provide some work on both. For each mode the component sessions have a suggested order: Mode Awareness (MA), Mode Management (MM), Experiential Mode Work (EMW). Awareness is necessary to move on to Mode Management or Experiential Mode Work. Table 4.1 lists each of the therapy assignments and handouts according to the group in which they should be used. It also provides the page numbers for where they can be found.

There is an *important caveat* in using a manual and structured program for ST. Although we specify the main mode, goal, and plan for each session, the mode or modes that patients are currently in must also be considered.

The Schema Therapy Clinician's Guide, First Edition. Joan M. Farrell, Neele Reiss, and Ida A. Shaw.
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Table 4.1 List of group handouts, exercises, and assignments by session, mode, and location

Group	*Assignments, Handouts*	*Title*	*Page #*
The Welcome Group (WE) 1 session, 50–60 minutes	Handout WEL 1	Group Ground Rules	40
	Handout WEL 2	The Bubble-Safety Technique	68
Schema Therapy Education Group (ST-ED) 5 sessions, 50–60 minutes	Handout ST-ED 1	What Is a Schema?	71
	Handout ST-ED 2	Identify Your Mode Experiences I	78
	Handout ST-ED 3	Identify Your Mode Experiences II	83
	Handout ST-ED 4	Schema Therapy	89
	Handout ST-ED 5	Identifying Modes	92
Mode Awareness Group (MA) 12 sessions, 50–60 minutes	Assignment MA 1-MCM1	Awareness of My Maladaptive Coping Mode	97
	Assignment MA 2a-DyPM1	Awareness of My Punitive Parent Mode	99
	Assignment MA 2b-DyPM1	Awareness of My Demanding Parent Mode	101
	Assignment MA 3-VCM1	Awareness of My Vulnerable Child Mode	103
	Assignment MA 4-ACM1	Awareness of My Angry Child Mode	105
	Assignment MA 5-HCM1	Awareness of My Happy Child Mode	107
	Assignment MA 6&12-HAM1&2	Accessing My Healthy Adult Mode	112
	Assignment MA 7-MCM2	Connecting with My Healthy Adult from My Coping Mode	115
	Assignment MA 8a-DyPM2	Letting My Healthy Adult Mode Banish My Punitive Parent Mode	117
	Assignment MA 8b-DyPM2	Letting My Healthy Adult Convert My Demanding Parent to Reasonable Standards	119

Table 4.1 (*Continued*)

Group	*Assignments, Handouts*	*Title*	*Page #*
	Assignment MA 9-VCM2	Enlisting My Healthy Adult to Care for My Vulnerable Child	121
	Assignment MA 10-ACM2	Enlisting My Healthy Adult to Listen to the Needs of My Angry Child	123
	Assignment MA 11-HCM2	Letting My Healthy Adult Mode Learn About My Identity by Listening to My Happy Child Mode	125
Mode Management Group (MM) 12 sessions, 90 minutes	Assignment MM 1-MCM1	Reducing the Power of the Maladaptive Coping Modes	131
	Assignment MM 2-DyPM1	Fighting Your Punitive and Demanding Parent Modes	147
	Assignment MM 3-VCM1	Caring for Your Vulnerable Child Mode's Feelings of Sadness and Anxiety	153
	Assignment MM 4-ACM1	Managing Your Angry Child Mode	159
	Assignment MM 5-HCM1	Developing Your Happy Child Mode	164
	Assignment MM 6-HAM1	Strengthening Your Healthy Adult Mode	168
	Assignment MM 7-MCM2	Reducing the Power of the Maladaptive Coping Modes – Long-Term Strategies	141
	Assignment MM 8-DyPM2	Long-Term Strategies to Fight Your Dysfunctional Parent Modes	172
	Assignment MM 9-VCM2	Long-Term Strategies to Meet the Needs of Your Vulnerable Child Mode	177

(*Continued*)

Table 4.1 (*Continued*)

Group	*Assignments, Handouts*	*Title*	*Page #*
	Assignment MM 10-ACM2	Long-Term Strategies to Manage Your Angry Child Mode	182
	Assignment MM 11-HCM2	Long-Term Strategies to Strengthen Your Happy Child Mode	185
	Assignment MM 12-HAM2	Long-Term Strategies to Strengthen Your Healthy Adult Mode	188
Experiential Mode Work Group (EMW) 12 sessions, 90 minutes	Exercise EMW-1-MCM1	Experiential Focusing Exercise	197
	Assignment 1 EMW 1&7 MCM 1&2	Scripts for the Schema Modes	198
	Assignment 2 EMW 1&7 MCM 1&2	Safe-Place Image Practice	209
	Handout EMW 2-DyPM1	Punishment and Reinforcement: How Do We Learn?	215
	Exercise EMW 2-DyPM1	Fighting the Punitive and Demanding Parent Modes: Things a "Good Parent" Would Say to a Loved Child	221
	Assignment EMW 2&8-DyPM 1&2	Practice: Recalling the Good Parent Script	224
	Assignment EMW 3&9-VCM 1&2	Practice: Imagery for the Vulnerable Child Mode	236
	Assignment EMW 4&10-ACM 1&2	Anger-Release Practice	245
	Assignment EMW 5-HCM 1	Imagery Practice for the Happy Child Mode	251
	Assignment EMW 6&12-HCM 1&2	Developing Your Healthy Adult Mode	257
	Assignment EMW 11-HCM2	Letting Your Happy Child Play	254

For example, it is the week of the ACM and you realize when you start the Mode Management group session that most of your patients are in their VCM. Do you ignore that and go ahead with your plan? In ST the answer is "no," not before you address the needs of those patients in some way. This can be done by acknowledging what you see and asking about the needs present. The answer is likely to be some version of fear or pain. So you use something soothing like the "safety-bubble" exercise or other soothing, protective strategy before going on with the plan for ACM. Before moving on, check out how successful the intervention was and then move on to the ACM work. In the worst case you may spend much of the session with the VCM and shorten the work on the ACM in that session. The ACM is a response to unmet needs, so addressing the VCM need should also diffuse the ACM. The VCM is a deeper level of experience than the ACM, so in a way you are taking advantage of the opportunity to get to the core level of mode-change work. If there is essential ACM work left undone, there will most likely be future opportunities to address it over the course of treatment when you find the group in ACM. ST is strategic work, so we are not suggesting that we go with whatever comes up in a session in the manner of process or psychodynamic groups. Addressing the mode present is an example of staying with the goals of ST while adjusting your specific plan for the session. On the other hand, if you continue with your plan and ignore the modes present, particularly the VCM, you are likely to hit resistance. You will also have violated a core principle of limited reparenting as you will not have responded to the need present and are likely to be experienced by patients as invalidating. The kind of flexibility described here is an aspect of ST that requires a higher level of skill from therapists than teaching skills groups. However, it is also this flexibility that makes ST so effective (Farrell, Shaw, & Webber, 2009) and results in high patient and therapist satisfaction with it (Reiss *et al.*, 2013b; Spinhoven *et al.*, 2007).

Practitioners new to ST can follow the recommended session order closely and use the corresponding patient materials described here. Experienced schema therapists may want to use the material by mode. Cognitive therapists can try out the experiential exercises provided and experiential therapists can make use of the cognitive and behavioral techniques also provided in the manual. Group therapists with no ST training can explore the ST conceptual model and try out the group exercises. We have attempted to assemble the sample therapist scripts and patient materials for maximum flexibility of use. All of the patient material in this manual has been tested in numerous patient groups and modified and refined based upon their response and post-group discussions. We suggest that patients be given loose-leaf binders in which they can assemble the material selected for them into a workbook.

4.1 General Therapist Tips for Group Schema Therapy

General Therapist Tips for GST

General Therapist Tips

1. Foundation tips

- Be warm, genuine, accepting, and present. Be yourself and trust your intuition.
- Ask yourself what a good parent would do. Act like a "good parent"; help patients identify their needs, try to meet them, and help them get needs met.
- Convey liking.
- Acknowledge patients by name.
- Validate patients' emotional experience.

2. Be like a symphony conductor

- In charge in terms of maintaining safety and the ST frame.
- Timing is important to a conducting a group – think of a symphony conductor who recognizes each member and pulls the best from all into a collaborative product.
- Quick to intervene to stop escalation – a member "out of tune."
- Nonverbally, gently gesture others to wait, to not interrupt the flow.
- Provide structure, particularly early on.
- Competent: know what to do or when to ask for additional outside help.
- Be creative and intuitive.
- Weave the group together for a cohesive whole.

3. Parenting style of the therapist

- Democratic within the limits of clinical judgment of what is safe and within the group ground rules.
- Collaborative: ask for input from co-leader or group members (e.g., "OK, what do we want to decide about this?" [situation of a member 10 minutes late, but with good reason]).
- Patience to allow affective process or give patient time to consider an answer.
- Use a supportive, cheerleading, interactive therapist style for the group as a whole.

- Attend to overall distress level and, if needed, use distress reduction exercise.
- Allow use of space and time out to regulate distress, e.g., pacing.
- Allow enough time for group members to answer questions, but not so much that it increases distress.
- Use examples from previous sessions to illustrate concepts. Use patient examples if you have permission.
- Get patients to verbalize what is different now and what they are doing differently to produce a better outcome.
- Reflect accurate reality testing in response to distorted perceptions, but do not question their feelings.
- Communicate acceptance and valuing of their person and question whether dysfunctional behavior actually meets their needs. Try to separate person and behavior.
- Pull for their strengths and acknowledge their accomplishments and contributions to the group.

4. Build the family by facilitating cohesiveness

- Weave little bits of personal information about members into didactic material so that they feel engaged and that you are interested in them. Weave a summary – e.g., "So Paula and Kristie both tend to default to a frozen DP, while for Kristalyn, Scott, Kyle, and Kathleen it is often the Angry Protector Mode and for Kelly and Rebecca Avoidant Protector is their usual coping style. Do I have it right?"
- Pull them in via examples from their experience that have been shared with the group, or if you aware of an example from individual sessions, ask their permission to share it. This should be done in a discreet manner that lets them know what you are referring to, but does not reveal too much unless you have permission. For example: "Sue, would it be alright for you or I to share a little bit with the group about your experience related to what Jane has shared?"
- Draw them in with related questions: "Have any of the rest of you felt that?"
- Recall their heads nodding to a question and comment on it then or later – e.g., "Paula, I recall that you were nodding when we talked about how worthless the PP can make a child feel, and so were you, Kathleen – so you two have experienced that?" Followed by a number of variations.

5. Therapist overall style

- Have a goal, but be flexible about your plan for the session. Use "opportunity work." Seize experiential moments.
- Stay active and prompt discussion – medium length (even short) silence usually leads to more Maladaptive Coping Modes due to anxiety or feelings of abandonment. However, do not lecture for a long period. If your group is not responding to your efforts, stop and address the process with something like a mode check. This can be as simple as "I am sensing a lot of detachment as I present this issue; what is going on for people?"
- Prompt discussion; don't let empty silences go on. Always have something to go to as a topic, question, or exercise.
- Attend intensely – stay connected, eye contact, nods.
- Use nonverbal behavior: e.g., lean forward, make inclusive gestures like open arms.
- Invite rather than push. Shape their involvement: e.g., allow patients to "pass" in the beginning.
- Convey interest: "Could you tell us a little more about what that was like for you?"
- Avoid labeling their feelings – help them discover their own emotion labels.
- Use selective self-disclosure of mode experiences. This makes us seem human and usually leads to more willingness on the patient's part to be vulnerable.
- Balance attention to each member. Be as fair a parent as you can.

6. Keep basic ST interventions in mind

- Always be aware of the modes and address underlying needs.
- Be supportive and accepting of the VC.
- Allow the AC to vent and feel heard.
- Set limits with ICM.
- Empathically confront coping modes. If Bully-Attack or Angry Protector Mode occurs, set immediate limits on negative effects on others.
- Limit the Dysfunctional Parent Modes and identify them as "not" the patient, rather the internalized negative aspects of early caregivers.

Source: Farrell and Shaw (2012)

One Therapist Focuses on the Group as a Whole While the Other Leads a Section of Work

1. If someone appears very distressed, go over and make contact by saying reassuring things like: "You are safe, you are OK, listen to the words, etc."
2. When we are processing the content, monitor the group when someone else is leading by making meaningful eye contact, nods, etc.
3. If you want to take the lead with someone, use the "touch the nose" signal. Otherwise it is difficult to know whether you will jump in. With this kind of group we need to not let silence go to the point that a patient jumps in and pulls the group away from the focus we have. This then acts as avoidance when we are trying to focus on difficult content. It is easier to prevent this loss of focus or avoidance than to bring it back, so the pace of intervention cannot be too slow. This group of patients does not respond well to silence that is too long.
4. On the other hand, remember not to jump in too quickly after your partner has just said something that a patient needs to think about. Remember not to "jump on the bandwagon" of the individual work another is doing, as it will leave the rest of the group unattended to. Only jump in if you think your partner's schemas are hooked or they are misunderstood or blundering.

Dealing with Conflicting Needs

As "parents" to a large family, we must consider all of the "children." It is important to clarify the boundaries for expression of anger in the group so that everyone will be safe and no one is hurt. Safety needs to be available for the other group members when anger is being expressed. Depending upon your group and the size of your group room, venting may need to take place with one of the therapists in a separate room. Identify for the group, either before or after, what the anger is about, to prevent fears that it is personal. Of course, it may reflect a conflict between members and, if so, it needs some mediation and resolution in the group. Sometimes this is not possible and the mediation may occur with the therapists and then be reported to the group. Empathic confrontation may need to take place privately, since individuals can feel exposed and vulnerable in the group. Other times,

if a disruptive behavior has occurred repeatedly in the group, empathic confrontation needs to take place there. We find it helpful to "set the stage" before beginning an empathic confrontation, then allow space for other members to get involved as long as it remains empathic and constructive. A therapist would need to intervene if what starts as empathic confrontation turns into "ganging up on" a patient. The group can give a member feedback about how they are affected by an Angry Child tantrum in group. Therapists can use selective self-disclosure to give feedback also as to the effects on them. Therapist feedback may take the form of "We love you, but feel hurt and angry about these repeated verbal attacks." A brief discussion of intent and effect and actor–observer differences in attribution can be useful groundwork to provide for giving such feedback. In working in group with personality disorder patients it is important at the cognitive level for them to understand the difference between intent and effect and that they are still responsible for the action they take. We coach the practice of more constructive, modulated expressions of anger, for example, milder expressions of anger for small irritants.

The therapists can emphasize that nothing can occur in the group that they cannot help with in some way. As a last resort, there could be a situation in which one therapist works with the individual patient and the other therapist responds to the needs of the rest of the group until a point is reached where all can resume the group's interaction.

Learning to Share Your Story in Short Segments or by Mode

In group sessions, the sharing of difficult childhood experiences is done in brief segments. In this way, over time, patients' "stories" are shared. This group-focused approach to sharing information is in contrast to individual psychotherapy where a block of time is dedicated to one individual. It is also different from the person-centered group model in which the same is done. On some occasions, one member may strongly want to share more of his/her story. If the story is not too detailed regarding abuse and it can be used to make the important basic point that "children are never to blame for abuse," we might let it go on briefly. We try to pay attention to slowing patients down if they are disclosing too much in early sessions to prevent them from feeling too embarrassed to come back or for the group to feel overwhelmed. The way we limit people's disclosure is to point out that we don't go into detail about painful or traumatic experiences because we don't want them to re-experience it. We explain that what is important in healing is to have the ending of the

experience changed so that what should have happened (i.e., a good parent there to protect them) will happen in imagery rescripting. Patients are usually relieved as they have often been told that they must tell it all and are typically afraid of feeling overwhelmed in doing so or of overwhelming others.

Shape Group Participation

Some patients (e.g., avoidant ones) may be reluctant at first to share content verbally, but they may nod (often only a very little bit, so be observant) in response to something, or if you ask everyone who has experienced fears around abandonment to raise their hand. Refer to any of these indications when discussing the material to make it as interactive as possible. Try to remember the specifics for each patient as this both conveys interest and helps them feel included in the group. Point out both commonalities in their experience and individual differences, as you want to model that both similarities and differences exist among group members.

De-Escalating High Emotion

We want the ST group to be a place where it is safe to express emotion. However, in the process of the group, at times it may be necessary to briefly de-escalate the intensity or prevent a conflict from getting intense. We simply stop the action and suggest that: "Everyone take a deep breath and let's do a quick check-in to make sure we all feel safe before continuing." This does not have to communicate to patients who are venting that they have to stop, rather it gives others the opportunity to move or do what they need to, in order to protect themselves. The message is that we will find a way for everyone in the group to get what they need even when those things are different. This message is a central, important one to give to our patients. It is also acceptable as therapists to stop the action so that we can take a deep breath and have a moment to think or to manage a mode of our own.

Dealing with Intense Memories, Flashbacks, and Dissociation

1. Help the patient who is experiencing the intense emotion, memory, re-experiencing, or flashback to return to his/her safe-place image (SPI) and "*Everyone can go back to your SPI, know that you are here with* (name the therapists present) *and all of your group, there are no unsafe people here, you are surrounded by safe people, and no one from the past can hurt you.*" This helps with reality orientation, as one would do individually to help a patient come out of a flashback

experience. Add anything else you think will facilitate being in today's reality with your specific group members.

2. Go into the experience in the role of "Good Parent" to stop whoever is threatening or hurting him/her. You can have the group members come into the image to stand around him/her protectively and you could say that they are providing witnesses and additional protection for the Vulnerable Child Mode.
3. We work with patients who dissociate to recognize early cues and use sensory and tactile interventions to prevent dissociation. For some patients, sitting across from one of the therapists or a particular peer and keeping eye contact helps them stay present. Some patients will want to sit next to therapists for this purpose and the connecting fleece pieces can also be used to establish a concrete connection. Staying connected can prevent dissociation. If a patient does dissociate and is not actively in distress, we might put one of the therapist-kit shawls around him/her and, if needed, explain to the group that he/she is safe. In a group where only one or two patients experience this, we would explain it as a version of Avoidant Protector at a point when the dissociated patient was back in connection with the group. (See Farrell & Shaw, 2012 for additional discussion of dissociation.)

Limited Reparenting for the Vulnerable Child Mode

In sessions where we access the Vulnerable Child Mode, therapists need to pay particular attention to using a warm, caring tone of voice and to provide comfort, including hugs if requested or if permission has been given. Physical contact is a sensitive area, but one that is important to patients in the VCM. The bottom line is that there should be no confusion about the contact being anything but supportive and not erotic or sexual. Interacting with patients in the VCM, our contact should be that of a good parent only. This means no more than the light hug we might give a close colleague (in some cultures), pat on the back or shoulder (not the knee or thigh), taking a hand for a brief period. What form the caring contact takes depends upon the norms of your culture, the ethical code of your setting, and your personal comfort. Affection appropriate to limited reparenting can always be done in imagery as well. Gender difference is also a consideration.

Therapy Assignments

We use assignments in a flexible way. Completing them is not the only acceptable response, particularly in early sessions. For example, it counts

if you "thought about it" or became aware of a barrier to completing the assignment (e.g., the topic triggered the Detached Protector Mode or another mode). This approach to assignments is very important as a way to encourage avoidant patients and any with failure and defectiveness/shame schemas to take the risk of trying. If not attempting assignments is a repeated issue, it can be discussed in a general way without singling anyone out. Discussing it in a supportive manner in the group is helpful as peers may have ideas from their experience about what the difficulty is and what some solutions might be. The experience of receiving help from the therapists and the group when they are having a problem is an effective antidote for the mistrust/abuse schema and Dysfunctional Parent Modes. This is an example of using the process and experiences that are possible in a group as well as the content.

Elaboration of the tasks of the group therapists and coordination of the two therapists as a team in GST can be found in Farrell and Shaw (2012).

4.2 The Welcome Group Session

The purpose of this group is as the title says – to welcome patients to the ST program. This group acts as an orientation to the program and to remind patients of some of the topics that were reviewed briefly with them during the assessment stage. We also think of it as an opportunity for an encouraging "pep talk" about the program and an opportunity to instill some hope.

Beginning the session

> *Hello. We want to give you a warm welcome to the ST group part of the treatment program. We are glad to see all of you here and happy that you have committed to be part of our program and this group. You don't know us or each other well yet, but over time all of the therapists are committed to the group being a safe place for all of you – like a healthy family environment – to work in. We look forward to working with all of you. I am* (give your name) *and in a few minutes we will all be introduced to each other in an exercise that we like to use to start the program. This first group session is all about making you feel welcome here, so we will be talking about what you can expect and we will answer any questions you may have. The way we establish safety and respect here is outlined in the ground rules that you were given when you were accepted for the program. We will go into them a little later because first we are going to do a short exercise to help us connect.*

Group Exercise 1: The Group Connection Exercise

> *We are going to do an exercise now with this ball of yarn. First I am going to wrap it twice around my hand so that I have a firm connection and then I am going to throw it to one of you. When I do, I will say my name and my role in the program. The other therapist(s* – plural as needed*) will all do the same thing. I would like each of you to tell us your name and where you are from. Wrap the yarn around your hand, not too tightly, and when you are ready to throw the ball, make eye contact with the person you are throwing to and let it go. That will help their chance of catching it. The last person who will be thrown to is T2.*

Patients and therapists toss the ball of yarn back and forth, each person connecting to the yarn by wrapping it around their hand so that a web of connections is constructed within the group circle. After all are connected once with the yarn, we have them make another connection around the circle from person to person. Then we comment on the added connections. [Make sure that you have a large enough ball to include everyone with the two connections.]

> *Now we are going to make a second connection. Wrap the yarn around your hand again and then pass it to the person on your right and say your name one more time. When it gets to T2, he/she will throw it across to me*. [After this is accomplished] *Be aware of all the connections we have right now, feel the strength of them* (the therapists playfully tug their various connections, making eye contact with group members and smiling). [In the rare occurrence of the yarn breaking – quickly tie a knot to bring the ends together and say "Fortunately, even if a connection breaks briefly here it can be restored."] *Take a snapshot of our connection matrix in your mind's eye that you can later bring to mind to remember your place in the group. Look at all the connections and see how we are all linked together. Every one of you is important to the group. You matter and are needed to make our group strong and whole.*

The next part of the exercise starts with the therapist and asks what each person wants one of their connections to represent or contribute to the group. T2 [whichever of the two therapists for that group who has not been leading so far] pulls on one of the strings attaching her to the group and says:

> *I want this string to represent trust*. (Then he/she looks to the right-hand patient.) *What do you want your connection to the group to represent?* (This is repeated until all have had a turn. After that, the therapist again points to the connections.) *Let's feel the strength of our connections again* (playful tugging). *I want you to pay close attention to what happens if I do this* (T1 lets go of the yarn). *Could you feel it? What if one more lets go? How was that, what did it do to our connection?* (Leave time for some responses.) *That is what happens when one of us is not here – a connection is lost.* [After brief discussion] *Let's restore our connection now. How does it feel when we do that?* [Despite patients having just met each other, they usually respond to the connection being dropped. If no one verbalizes this, the therapist can model a reaction of some loss or difference in energy or even temperature – less warm.] *We aren't going to keep this in place all the time, but when we want to really feel our connection reinforced we can bring it out. For now, let's lay it down on the floor in front of us. We do have some ways to keep your awareness of our connection in the group.*

Therapist Tip

This is usually a positive exercise for patients. If a problem arises, try to deal with it in terms of the ST model. For example, if someone feels uncomfortable with the connection, don't force it, rather support them connecting at whatever level they can. That may mean sitting in the group with the connecting yarn attached to their chair, not their body, or if they do not feel safe connecting with the group as a whole, but have therapists or patients they feel safe with, let them use a piece of yarn to connect with that person. Be creative, as all you are trying to accomplish is the beginning of connection.

The middle of the session

We emphasize connection since work on secure attachment is an important concept in ST and bonding is where treatment begins. At this point we want to give patients a tangible object that symbolizes their membership in the group. A number of different variations have been tried and we list them here for you to choose from, or develop your own for your setting and group.

Variation 1: Give each patient a piece of the yarn to take with them to represent the group connection. Be sure to cut it from the same ball of yarn that was used, but not the portion that actually connected the patients and therapists. We learned the hard way when we cut the yarn we had used and patients felt that we had cut their connections. Psychotherapists in the Netherlands modified this to have patients tie the yarn around their wrists like a bracelet. They told their patients about the custom in Asia of having a string from the temple and wearing it as a bracelet until it fell off. That group liked the idea and added that when it wore off they would do the exercise again to have a new piece and renew the connection. These patients expressed shock at the next session when they saw that their therapists were still wearing the group string-bracelets. They were surprised that the group meant enough to the therapists for them to keep the strings on. This suggests that the bracelet exercise can also strengthen or deepen the group's feelings of connection with the therapists.

Variation 2: Give each patient a glass bead that represents the group to place on the string and have the person sitting next to you in the circle tie the bracelet with the bead onto your wrist. We call this one the "bead of membership" and it is very popular with male and female patients. We have people whom we met with years later who still had their beads made into a key chain or on the string in their purse. (See Therapist Instructions – Welcome Group: The Group Identity Bracelet (WEL-TI).) This variation can be followed up with additional beads for various other group experiences or events. For example, a bead to represent your safe place, to remember your little vulnerable child, etc.

Variation 3: We have worked with art therapists who had their groups paint the connecting web: making drawings, taking photos, or moving the web literally into paint and then moving it onto a huge piece of paper to have a quite literal representation.

Therapist Instructions –Welcome Group: The Group Identity Bracelet

◯ **A "Progressive Transitional Object"**

Inexpensive, but varied in shape, color, size, beads are given to patients at the following times and any other event that you want to mark or anchor in memory:

1. A bead at the beginning to represent membership in the group.
2. A bead that represents their safe place.
3. "Good Parent" beads from the therapists.
4. A bead for having the strength to break through their DP (one of the beads that will come to represent their Healthy Adult mode).
5. A bead to remember to be gentle with their Vulnerable Child.
6. A bead for the Happy Child. This can be connected to a group memory of play.
7. A bead to represent awareness of various Healthy Adult strengths or accomplishments. For cohesiveness, do this for each group member so that no one feels left out. To keep it genuine, the bead can represent a strength or ability that the group member is working to strengthen or claim.
8. Beads can be given for various other experiences – the group reaching the positive working stage, handling a conflict well as a group, etc.
9. A bead to mark different stages of growth – either for the individual and/or as a group.
10. A bead can be given before a holiday or vacation for reassurance and as a sort of transitional object.
11. All patients and therapists can exchange beads at review points – for example, when the case conceptualization has been completed.

Information about how GST works and what is required of the group members

We next discuss how the group works, what to expect, and what is required of the members of the group. We refer to the information they were given in the assessment sessions for the program (Section 3.6). The section below lists the main points that we want to make. Depending upon your group and setting, you may add or subtract so that the information matches.

Introduction to imagery

Imagery in a variety of forms is an important part of experiential work in ST. Thus, the ability to do imagery is an important capacity to facilitate in patients. The ability to use safety images sets the stage for patients to be able to suspend their use of Maladaptive Coping Modes in group sessions. Healthier

Sample Therapist Script: About Group Schema Therapy

We tell them how critical their role is to the group's success and that they are all important to us and to the group. We tell them that we care about all of them and want them to be part of the group "family."

- We tell them what patients with the same problems have said about the group experience; that they have a sense of belonging, feeling understood and accepted, and "there are people like me" for the first time. We add that these positive feelings may take time to develop and that initial negative reactions may be a result of protective coping modes.
- We describe the ST concept of limited reparenting and the role of the therapists in keeping everyone safe, setting limits when needed, and preventing any verbal attacks or aggression.
- We remind them of the ground rules in a supportive manner and tell them that we will support them being able to follow them for the sake of a positive group environment.
- We stress the importance of their commitment to, and respect for, the group and other members (e.g., confidentiality, being on time, not interrupting, no name calling, good communication basics).
- We describe the therapists' role in the group: that we are sometimes like the conductor of an orchestra and at others like a referee. We tell them that our goal is to respond in the way a good parent would for a loved child when they are in child modes; that we will play different roles in response to the different modes they are in. When they are in the VCM we will be validating and supportive, for the ACM we will hear them and let them vent, but help them channel their anger in a nondestructive way and separate angry feelings from actions taken.
- Ground rules are listed in Section 3.6 and the patient handout is Welcome Group Handout 1: GST Ground Rules (WEL 1).

An example of some of the statements we make in this session: *We want this group to be an important support, like a healthy family can be – but that will take some time and work from all of us. You may find yourself having reactions to other people in the group, including the therapists. We are asking you to stay open to getting beyond first impressions, to actually getting to know your fellow group members and letting us know you. The process of forming a group can be anxiety-producing at times.*

"replacement" coping strategies must be developed before we can expect our patients to abandon the only way of coping they know. After all, these were the survival strategies that worked to keep them alive in childhood and they are still experienced as protecting them from overwhelming, frightening, painful feelings that occur when the child modes are triggered in the present. Safety imagery is one of the replacement coping strategies for patients to use to be able to stay present when strong emotion is triggered rather than going with a Maladaptive Coping Mode like the Detached Protector. When teaching imagery to patients, they frequently claim a total inability to visualize and talk about their "failures" in mindfulness groups. So, we begin with a vivid story that seems to appeal to the child in all of us – a visit to an ice cream store with the opportunity to pick out whatever you want in whatever form and amount.

Sample Therapist Script: The Visit to the Ice Cream Store



I want to tell you a story and I would like you to just close your eyes (or look down), and be aware of any feelings you have as you listen. Today in my mail I received a card from my favorite ice cream store that said I had won the Ice Cream Giveaway Contest. It said that I could bring 10 people with me and we could have absolutely anything that we wanted to eat. So I am inviting all of you. So we get to the store and the owner greets us enthusiastically and tells me to start, to go ahead and help myself. So first I choose my cone – I take a waffle cone dipped in chocolate and then rolled in cashews. I put first a scoop of chocolate in the bottom, then a scoop of caramel, then some vanilla bean. I see some chopped-up Kit-Kat bars, so I add those, and some fluffy marshmallow topping, so I add that. It is enormous by now, but still I add a ladle of hot fudge and top it with whipped cream and chopped cashews. Now it is your turn, so choose whatever you would like and put it together just like you want to. [Wait about a minute or two.] *OK, did everyone have time to choose their ice cream?* [Wait for nods yes.] *Open your eyes and come back to the group.* [Then turn to the patient next to you and ask:] *What did you choose?* [After a quick go-around to share this information, T1 declares:] *You have just done imagery. Wow, all of you could do it! That is wonderful! We knew you could do it!* [and is very positive about their ability].

We have rarely had a patient not spontaneously explain what they chose. When we have, it has either been an anorexic patient and the solution was for her to take an expresso from the store instead, or a few patients who said they did not deserve to be included. The answer to that is that the therapist thinks so or she would not have invited him/her. If there is still resistance, we tell them that we think they are deserving and we will keep it in a cooler for them until they feel that way too. The point is that we roll with any negative responses and do not get stuck or try to convince the patients of something that they do not feel.

Therapist Tip

The story should be told dramatically with great enthusiasm. Patients tend to get caught up in the story despite themselves. The word *enthusiasm* is important to note. As a group therapist, when we can be open and genuine in sharing our Happy Child Mode delight and playfulness in an exercise we lead, it is easier for patients to get caught up in the emotion as well. It is as if we have called their Happy Child part out to play and the "game" seems like fun. Being able and willing to invest our own emotion in our interactions as a therapist is crucial for effective GST. Just as schema therapists have many differences in personality, temperament, and schema profile, there are many different ways to engage with patients. We three authors have distinct differences in style. Patients respond to us at different times and for different needs. What is critical is that you be genuine and true to yourself. Of course, you must also be aware of times when your schemas and modes are triggered. That is discussed in Chapter 6 on supervision.

After demonstrating to the group that they are able to do imagery, we move on to the first safety image. We chose this one because it is unlikely to be connected with any other schema-triggering situations and it is one that joins the group together in safety and the safe place is the actual group. Later on, we help patients develop personal safe-place images.

Group Exercise 2: The Group Safety-Bubble

The first safety image that we present to patients is a simple image we have found to work with a wide variety of patients. This is an imagery exercise in which we put a huge "magical safety-bubble" around the whole group. This fits with the developmental approach of ST which suggests that safety and protection initially need to come from the therapists.

Sample Therapist Script

Either close your eyes or look down and take a few deep, slow breaths and just feel any tension leave your body and mind. Imagine that we are surrounded by a huge transparent bubble large enough for all of us to fit inside comfortably and filling up the group space. It is a beautiful bubble with all of the colors of the rainbow. You notice that it even has a wonderful fragrance to it. It is a magic bubble that can protects us from anything outside of it. No unhealthy parent voices or critics can get through its walls. It is unbreakable – no one can get in, but you can walk in and out of it if you need to or take it with you as you move. Bring into the bubble any comfort objects that you like. You can take into the bubble anything you want that will be soothing to you and help you feel strong and safe. No one can bring anything in that could be used for harm. The bubble symbolizes the safe cocoon we have here in the space of the group. T2 and I will not let you be harmed here. We will protect you and "have your back." All of you are valuable to us and we want you to know that here you are safe. Just take in the warmth, safety, and connections of the bubble. Stay focused on these feelings for a few minutes and keep your breathing deep and slow. When we come back to having our eyes open, let the bubble stay protectively around us. If you feel the need for your own bubble, imagine that you have a smaller one that is just around you. It is even one that you will be able to take home with you. We will all connect with it again before you leave today.

Welcome Group Handout 2: The Bubble-Safety Technique

Uses of the Bubble Technique Outside of Group

Bubble technique 1

Imagine a bubble large enough for you to fit inside. Imagine it in any color you like and as beautiful as you want to make it. It is a magic bubble because you can walk in and out of it without breaking it. You can take into the bubble anything you want that will be soothing to you and help you feel strong and safe. You may let other people in or you may choose to be by yourself. One thing you may not take in is anything harmful to you or unhealthy. When you are in your bubble, you won't need those things because you feel so safe and relaxed there.

After you are able to imagine your bubble and have gone into it with whatever you want, imagine the bubble floating away to wherever you want it to go. You may want to close your eyes and maybe even listen to peaceful music as you float away in your safe bubble. No unhealthy parent voices or critics can get through the magic bubble. You may stay in your bubble for as



long as you want to or need to. It is best to stay there until you think you can come out and be safe. After you come out of your bubble, relax for a few minutes before you do anything else.

Bubble technique 2

For this technique, imagine a bubble, but this time do not put yourself or your belongings into it. Instead, put anything that is bothering you into the bubble. For example, you may want to put into it the voices that bother you or you may want to put in your urge to harm yourself. The point is to put negative things into it. Once you have put in everything you want to get rid of, seal up the bubble and send it away. Close your eyes and imagine the bubble floating high and far away from you until you can no longer see it. When you feel safe from the negative things, open your eyes and slowly resume your day.

Practice both of these techniques every day and write in your journal about your experiences with using this imagery technique.

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Therapist Tip

When it comes to imagery or other experiential exercises, patients may object to participating, saying it is "silly" or even "bullshit" and refusing to try it. We avoid ending up in a battle over this. We may say: "*I am so glad that you spoke up to tell me you felt it is silly. That took courage. Good for you. I can see how you would think it sounds silly* before *trying it. Let's see if you feel that same way after you try it. We have found it to help many people*." More often than not, they then try it.

Another complaint is "I cannot possibly use a bubble." So, come up with something that will be appealing: "*OK, what about a brand new car, a Hummer, with all the safety measures available?*" It could be a fortress or whatever you can think of or the patient offers. It is important not to ignore their objections but to work with them and be flexible. We "choose our battles" and usually limit them to situations that are dangerous for them or others. Arguing with them usually triggers their Angry Child Mode or a Maladaptive Coping Mode that will make it even more difficult to

reach them. Another alternative is to suggest an individual safety-bubble – same image, but a separate bubble of their own. It can have some kind of connection to the group and the person in the individual bubble is welcome to come in when they want to.

On rare occasions we will have a patient who will not try anything. Here is an example of what we say: "*OK, I will respect that today, but I will ask you on another day to respect me and try the exercise. Is that a deal?*" or the approach of "*Good that you are taking care of yourself. Would a pillow or blanket help you feel safe enough while we try the exercise?*"

Usually they take the soothing object and you can incorporate that and them into the imagery. For example, "*So we are all in this protective bubble together and we can see Jean over there with the comfort blanket wrapped around her, looking peaceful and calm.*" You can pull her into the bubble in gradual steps. For example, have her come closer in imagery and reach out to take her hand from the safety bubble or whatever creative thought that comes to you. If you keep trying, stop at two ideas and let her safely be in the room. She may not be able to join at first and as long as that is acknowledged, it does not have to be such a big deal.

4.3 Five Schema Therapy Education (STE) Sessions

At the beginning of ST treatment, patients need to learn about the core concepts of Schema Therapy, such as schemas and modes and how to understand their presenting problems in ST terms. The materials of the ST Education group give patients and therapists the needed exercises and handouts to accomplish this. The materials are designed for use in group sessions and for therapy assignments. Generally the ST Education group is the one that begins treatment. We suggest not starting the other component sessions until after the second session of the ST Education group has taken place. After that, work on the MCMs in other groups can begin. In intensive treatment settings, it is advisable to have one hour of ST Education group daily during the first week of treatment. In outpatient settings and possibly only one group per week, we would also suggest starting with the ST Education sessions, before moving on to the other components. Approaching the program in this way allows patients to begin to feel safe and not be overwhelmed by a treatment model new to them. ST language is user-friendly for patients and within a short time they will understand and use the terms. Individuals and patients also come up with their own names for modes and this is encouraged. The Detached Protector Mode may become the "Space Cadet" and the PPM – the "Punisher," etc.

In **Session 1 of ST Education** patients learn what schemas and modes are and how they develop. Patients must understand that schemas are pervasive and trait-like structures that form our specific ways of seeing, feeling, and experiencing the world, ourselves, and other people. Schemas have a number of components, such as cognitive, emotional, and even physiological components. Schemas help us to structure our world, but when they are dysfunctional they make it difficult for us to adapt to changes in our environment. Furthermore, patients need to understand that dysfunctional schemas develop when normal childhood needs are not fulfilled. On the handout **Schema Therapy Education Session 1: What Is a Schema?** (ST-ED 1) core childhood needs are identified and patients are encouraged to talk about how these needs were or were not fulfilled in their childhoods. This can be very emotional for some patients who suddenly feel the impact of not having had their needs fulfilled. Since there is only limited time available in group, it is always possible to refer patients back to the IST sessions, if they feel they want to know more about childhood needs and work on their individual unfulfilled childhood needs.

Usually there is not enough time in session 1 to go through all 15 schemas. All the schemas are listed in the last part of the materials of session 1. It can be suggested that patients read about the schemas as a therapy assignment. If patients have very specific questions about their own schemas, refer them to IST.

Schema Therapy Education Session 1: What Is a Schema?

A Schema Is a Pattern

It develops during childhood and adolescence and is activated again and again during your life. Since a schema gets more rigid over time, our reactions become less flexible. One result of this is that our schema-based reactions don't really fit the requirements of many present situations.

There Are Adaptive and Maladaptive Schemas

A maladaptive schema:

- is self-injurious;
- is rooted in something that has been done to us (e.g., criticism, neglect, invalidation, abuse, overdone protection);

- dominates our life so that we experience repetitions of these harmful situations (e.g., we might stay in an unhealthy romantic relationship);
- makes us react in a manner that is self-defeating and usually inflexible in situations that are similar to those that harmed us in our childhood development;
- makes it difficult for us to successfully meet the demands of some important situations in our adult life.

In Schema Therapy these are referred to as Early Maladaptive Schemas or EMS.

How Do Schemas Develop?

Schemas (EMS) develop from the interaction of temperament and unmet childhood needs

I. Temperament is inherited. It is our own specific way of reacting to the world. It is a "hard-wired" neurobiological aspect of us that we are born with. As children, we cannot control our temperament. Research suggests that people with psychiatric disorders have a more sensitive and reactive temperament.

II. Unmet needs refers to how well my early caretakers and environment met my basic, normal childhood needs.



What are normal childhood "needs"?

Research on child development is in agreement that there are five core needs that all children have:

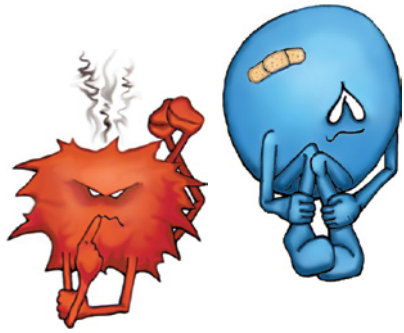
1. secure attachment (safety, stability, nurturance, acceptance; includes the sense of belonging);
2. autonomy, competence, and a sense of identity (being allowed to do age-appropriate tasks on your own, and being given accurate feedback about yourself);

3. freedom (to express your own feelings and needs);
4. spontaneity and play (self-expression and the ability to enjoy life);
5. realistic limits (to learn age-appropriate self control).

Too little or too much fulfillment of needs leads to the development of maladaptive schemas!

How maladaptive schemas develop and affect us now

1. If you have the schema Abandonment, then …
   … as a child you did not get the need for safety, security, or predictability met by your early caretakers.
   … as an adult, when this schema is triggered you can have the feeling that you are unsafe, all alone, with no one to give you the safety, emotional support, connection, strength, or protection you desperately need and little way to provide it for yourself.
2. If I have the schema Defectiveness, then I …
   … have the feeling that I am flawed, worthless, bad, incapable, or useless in important aspects of my life.
3. If I have the schema Mistrust/Abuse, then I …
   … have the expectation that others will lie to me, cheat, hurt or abuse me, manipulate, shame, or use me.
4. If I have the schema Emotional Deprivation, then I …
   … have the expectation that my need for emotional support, attention, understanding, empathy, and help will never be fulfilled sufficiently by other people.
5. If I have the schema Undisciplined, then I …
   … have difficulty with self-control; for example, I express my feelings and impulses in an extreme manner.
   … or I have a low frustration tolerance in trying to reach my own goals; for example, I don't like making a sustained effort.
6. If I have the schema Isolation, then I …



… have the feeling of being isolated from the rest of the world or that I am different from other people or that I am not part of a group, that I don't belong.

7. If I have the schema Dependency/Incompetence, then I …
   … am convinced that without large amounts of support from others I won't be able to manage daily life.
8. If I have the schema Vulnerability to Illness/Harm, then I …
   … constantly fear catastrophes that I cannot prevent from happening.
9. If I have the schema Enmeshment, then I …
   … attach too strongly to one or more people in my life and try to be close to them to the point that I have no social life or interests of my own.
10. If I have the schema Failure, then I …
    … am convinced that I have failed or I am going to fail in areas where performance counts, such as sports, school, or job.
11. If I have the schema Grandiosity, then I …
    … am convinced that I am better than others or special or that I have more rights than others.
12. If I have the schema Subjugation, then I …
    … easily give control to others because I feel that I must (for example, out of fear of consequences).
13. If I have the schema Self-Sacrifice, then I …
    … try excessively in daily situations to fulfill the needs of others at the cost of my own happiness.
14. If I have the schema Attention-Seeking, then I …
    … try excessively to achieve the approval, praise, or attention of others or I try to fit in at the cost of developing my own true feelings.
15. If I have the schema Negativity, then I …
    … focus on the negative aspects of everything throughout my life (e.g., the "glass is half empty" approach to life).
16. If I have the schema Emotional Inhibition, then I …
    … excessively inhibit my spontaneous feelings, actions, or communication, usually to avoid feelings of dislike or shame, or to avoid losing control over my impulses.

17. If I have the schema Unrelenting Standards, then I …
    … am convinced that I must work constantly to try to meet my own very high standards for behavior and achievement, to avoid criticism from myself or others.
18. If I have the schema Punishment, then I …
    … am convinced that people should be punished harshly if they make mistakes.

○

- ✓ Schemas are like the "issues" or problem areas that a person struggles with.
- ✓ Schemas are not active all of the time. They have to be activated or set off by something – usually a situation you are in or an interaction with someone.
- ✓ When our schemas are activated, intense states are triggered that include feelings, sensations, thoughts, actions, and sometimes memories.
- ✓ These states are called **modes** in Schema Therapy. Modes will be the focus of most of your work in this program.
- ✓ We provide this list of schemas for you to think about and you may discuss them with your individual therapist as part of developing your individual treatment plan.

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Schema Modes Explained

Schema modes are the moment-to-moment emotional states and coping responses that we all experience. Often our schema modes are triggered by life situations that we are overly sensitive to (our "emotional buttons"). A schema mode is triggered when schemas are activated. Schema modes are comprised of strong emotions and/or rigid coping styles that take over and control an individual's functioning.

The mode we are in can change rapidly and modes can overlap with each other. We refer to this as "mode-flipping" and it is very common in people with psychiatric disorders. Mode-flipping feels scary, "crazy," overwhelming, and it is exhausting.

Modes we will focus on

1. Maladaptive Coping Modes are the survival strategies we used in childhood to protect ourselves from the emotions that go along with hurt, pain, neglect and abuse:

   ✓ Avoidant Modes
   ✓ Overcompensation Modes
   ✓ Surrender Modes

2. Child Modes occur in response to our needs not being met:

   ✓ Vulnerable Child Mode
   ✓ Angry/Impulsive Child Mode

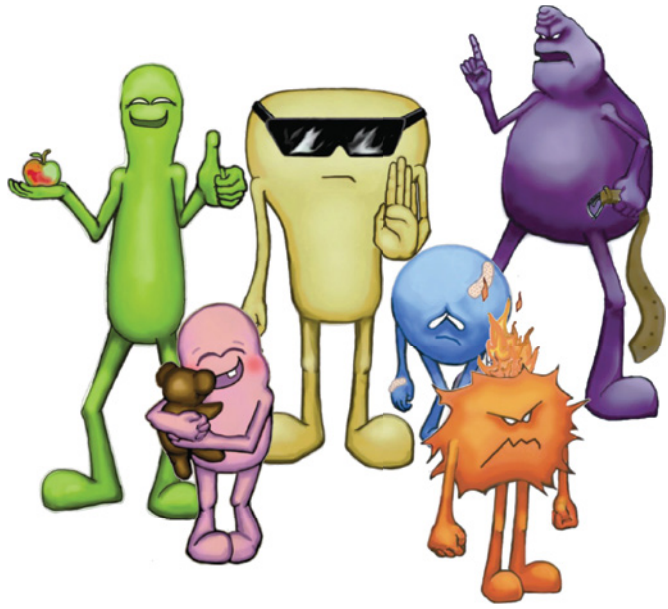
3. Dysfunctional Parent Modes are the internalization of the negative aspects of our childhood caretakers and the feelings that went along with our childhood experience of them.

   ✓ Punitive Parent Mode
   ✓ Demanding Parent Mode

4. Healthy modes are adaptive responses to our adult environment and the ability to access creative joyful aspects of childhood:

   ✓ Healthy Adult Mode
   ✓ Happy Child Mode

Meet the Mode Family



The next two sessions, **Schema Therapy Education Sessions 2 and 3**, go into more depth on the schema modes. The structure of the handouts is similar. The goal is to understand the cognitive, emotional, physiological, and behavioral component of each mode for each patient. **Session 2** focuses on the MCMs, Innate Child Modes and DyPMs. When we present the DyPMs, we make it clear that the source of this negative critical internalization does not have to be a parent – it can be the critical or punitive voice of an early caregiver, a childhood bully, or an adolescent peer group. When it is a parent, it is helpful, for some patients who may struggle with family loyalty, that we are talking only about the selective negative aspects of a parent, not suggesting that they are "all bad" or that they have to lose their real parent. **Session 3** describes the healthy modes, the HCM and the HAM. It is important to clarify that everyone has a Happy Child and a HAM, even if it is very weak or infrequently experienced. It is helpful to give them specific examples of their Happy Child or HAM, if you have observed them. If you have not observed any Healthy Adult behavior of

your patient, you can always use the fact that they have come to treatment as an example of HAM behavior. Give examples of typical thoughts, behaviors, or feelings for each mode, including some self-disclosure of your own mode experiences within therapeutic limits. Self-disclosure is one of the ways in which therapists in ST demonstrate that they are "real people," genuine and at times vulnerable. It is important to make the point that we all experience modes, but when modes are severe or frequent and interfere with healthy functioning in daily life and getting one's adult needs met, they need treatment.

Schema Therapy Education Session 2: Identify Your Mode Experiences I

1. Maladaptive Coping Modes



- In a Coping Mode, you can keep all feelings far away. This can be helpful in survival or abuse situations but if used too much it leads to chronic feelings of inner emptiness.
- Another drawback to using this mode a lot is that when in a Coping Mode you cannot access *any* feelings – painful or positive, not even in therapy sessions!
- In a Coping Mode you may: cut off needs and feelings; detach emotionally from people and reject their help; feel withdrawn, spacey, distracted, disconnected, depersonalized, empty, or bored; pursue distracting, self-soothing, or self-stimulating activities to excess; have a cynical, aloof, or pessimistic stance to avoid investing in people or activities.

If I am in a Maladaptive Coping Mode, I feel (feelings):

_____

_____

_____

If I am in a Maladaptive Coping Mode, I think (thoughts):

_____

_____

_____

Typical actions that I take in the Maladaptive Coping Mode:

_____

_____

_____

Typical situations that trigger the Maladaptive Coping Mode:

_____

_____

_____

Three versions of Maladaptive Coping Modes

The Maladaptive Coping Modes that we will look at are all versions of humans' automatic emergency reactions when survival is threatened: flight, fight, and freeze. They developed in childhood to allow you to survive not having your core needs met. They are meant for emergency situations, but you are overusing them. Today their use keeps others at a distance, creates interpersonal problems, keeps all feelings away, and limits your ability to deal with the demands of your life successfully. The Coping Modes are trying to protect the Child Modes, especially the Vulnerable Child, from suffering more.

Avoidance – flight



- Associated with the reaction strategy: FLIGHT.
- Protects by avoiding, running away, self-soothing, psychological withdrawal, dissociation.
- Strategies this protector uses are sleeping, online-chats or just not showing up.
- One of the places this protector shows up is in achievement situations.

Overcompensation – fight



- Associated with the reaction strategy: FIGHT.
- Protects by being unfriendly, cold, or hostile towards others, thus pushing them away to protect from being hurt.
- Bully-Attack; if he/she feels hurt – retaliates to hurt back.

- Can be sarcastic or cynical, sometimes uses "black humor," passively aggressive.
- Self-Aggrandizer: believes and acts as if better than others.

Surrender – freeze



- Associated with the reaction strategy: FREEZE.
- This way of coping is giving in to or accepting your schemas – e.g., surrender to defectiveness would be accepting that you are defective.
- It is a kind of giving up.

2. Vulnerable Child Mode



- The mode in which our needs for attachment and safety are the strongest.
- The mode that contains the schemas that affect us the most and can trigger the Coping Modes.
- In this mode people feel some or all of the following: lonely, isolated, sad, misunderstood, unsupported, defective, deprived, overwhelmed, incompetent, doubts self, needy, helpless, hopeless, frightened, anxious, worried, victimized, worthless, unloved, unlovable, lost, directionless, fragile, weak, defeated, oppressed, powerless, left out, excluded, pessimistic.

If I am in my Vulnerable Child Mode, I feel (feelings):

_____

_____

_____

If I am in my Vulnerable Child Mode, I think (thoughts):

_____

_____

_____

Typical actions that I take in my Vulnerable Child Mode:

_____

_____

_____

Typical situations that trigger my Vulnerable Child Mode:

_____

_____

_____

○ **3. Angry/Impulsive Child Mode**



- In this mode people feel some or all of the following: intensely angry, enraged, infuriated, frustrated, impatient – because the core emotional (or physical) needs of the vulnerable child are not being met.
- In the Angry Child Mode, you may vent strong feelings that have been held back for a long time and are not just about the present situation you are in.
- In the Impulsive Child Mode you may feel what the Angry Child does, but also act in a selfish or uncontrolled manner to get your needs met and you may appear "spoiled."
- Angry/Impulsive Child behavior often leads to difficulties with other people.

○ If I am in my Angry/Impulsive Child Mode, I feel (feelings):

_____

_____

_____

If I am in my Angry/Impulsive Child Mode, I think (thoughts):

_____

_____

_____

Typical actions that I take in my Angry/Impulsive Child Mode:

_____

_____

_____

Typical situations that trigger my Angry/Impulsive Child Mode:

_____

_____

_____

_____

Goals of Schema Therapy for These Modes

Strengthen and develop your Healthy Adult so that he/she is able to:

1. Reassure and replace the Maladaptive Coping Modes:
   - Recognize that your old coping strategy helped you to survive childhood, but does not get your needs met today.
   - Recognize the limits of this mode in your adult life.
   - Experience emotions as they arise, without blocking.
   - Connect to others, establish stable relationships.
   - Express your needs.
2. Care for and protect your Vulnerable Child:
   - Deal with unmet needs for safety, caring, autonomy, self-expression, and connection.
   - Do what a good parent would do for a beloved child.
   - Be able to self-soothe.
   - Be able to support the Vulnerable Child when frightened or taking on challenges.
3. Validate the emotions and needs of the Angry Child and channel the action of the Impulsive Child into healthy action:
   - Learn the difference between feeling angry and acting impulsively.
   - Act assertively to meet the Angry Child's need within the limits of the situation.
   - Learn healthy ways to express anger.



Schema Therapy Education Session 3: Identify Your Mode Experiences II

1. Punitive/Demanding Parent Mode



- In these modes you are dominated by the messages and views of early punitive or neglecting caretakers or authority figures (parents, teachers, coaches, peers, bullies, etc.) from your childhood and adolescence.
- These modes contain all of the inner anger/hatred/rejection etc. that you experienced as a child.
- In the Punitive Parent Mode you feel that you deserve punishment or blame and you often act on these feelings by being blaming, punishing, or abusive toward yourself (e.g., self-injury).
- In the Demanding Parent Mode you feel that you must be perfect, achieve at a very high level, keep everything in order, strive for high status, put others' needs before your own, or be efficient and avoid wasting time. You feel it is wrong to express feelings or to act spontaneously.
- The difference between the two versions is that the Punitive Parent focuses on how rules are enforced and the Demanding Parent focuses on the standards and rules themselves, not their enforcement. A Punitive Parent may or may not be demanding and a Demanding Parent may or may not be punitive.

If I am in my Punitive/Demanding Parent Mode, I feel (feelings):

_____

_____

_____

If I am in my Punitive/Demanding Parent Mode, I think (thoughts):

_____

_____

_____

Typical actions that I take in the Punitive/Demanding Parent Mode:

Typical situations that trigger the Punitive/Demanding Parent Mode:

2. Healthy Adult Mode

- In this mode we nurture, validate, and affirm our Vulnerable Child part; set limits for our Angry and Impulsive Child parts; promote and support our Happy Child part; combat and eventually replace the Maladaptive Coping Modes; neutralize or moderate the Maladaptive Parent parts.
- Healthy Adult is the mode in which we are able to balance taking care of our needs with our role responsibilities and tasks and be able to enjoy life.
- People with psychiatric disorders often have not had the supportive childhood environment needed to develop their Healthy Adult Mode. However, this can change through your work in Schema Therapy. Healthy Adult is the part of you that is strengthened and developed in Schema Therapy.



If I am in Healthy Adult Mode, I feel (feelings):

If I am in Healthy Adult Mode, I think (thoughts):

_____
_____
_____

Typical actions that I take in the Healthy Adult Mode:

_____
_____
_____

Typical situations that pull for the Healthy Adult Mode:

_____
_____
_____
_____

3. Happy Child Mode



- In this mode we feel loved, contented, connected, satisfied, fulfilled, protected, praised, worthwhile, nurtured, guided, understood, validated, self-confident, competent, appropriately autonomous or self-reliant, safe, resilient, strong, in control, adaptable, optimistic and spontaneous.
- Our core emotional needs are currently met, if we are in this mode.
- People with psychiatric disorders often have not had a childhood environment that supported them being be happy or playful. So, they often don't know what they enjoy doing, they haven't developed any hobbies or recreational activities for their lives. Learning more about and developing the Happy Child Mode will give your Healthy Adult a needed sense of play and fun.

If I am in Happy Child Mode, I feel (feelings):

_____
_____
_____

If I am in Happy Child Mode, I think (thoughts):

_____
_____
_____

Typical actions that I take in Happy Child Mode are:

_____
_____
_____

Typical situations that pull for Happy Child Mode:

_____
_____
_____
_____

Goals of Schema Therapy for These Modes

Strengthen and develop your Healthy Adult so that he/she is able to:

1. Eliminate dysfunctional parent modes:
   a) Overthrow and banish the Punitive Parent.
      - Recognize the source of this mode and know it isn't really you.
      - Learn to ignore this voice rather than getting hooked into defending yourself.
      - Replace self-punishment with healthier responses like experiencing appropriate remorse, making restitution, taking the responsibility that is yours, working on change when needed.
      - Recognize that reinforcing the positive works better than punishment.
   b) Convert the Demanding Parent to reasonable standards:
      - Learn to accept what is "good enough."
      - Learn to give yourself breaks.
      - Work for the accomplishments that are meaningful to you.
2. Further develop the healthy modes:
   a) Develop the Healthy Adult Mode so that you can:
      - Access this part of you when needed.
      - Realize your potential. Recognize your strength. Accept sincere praise.

- Form and maintain healthy relationships.
- Form an accurate and stable sense of identity.

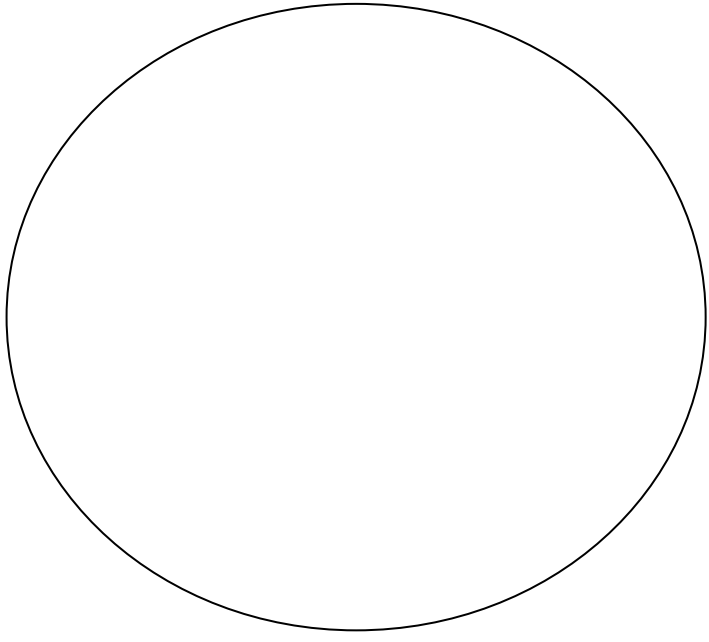
b) Develop the Happy Child Mode so that you can:

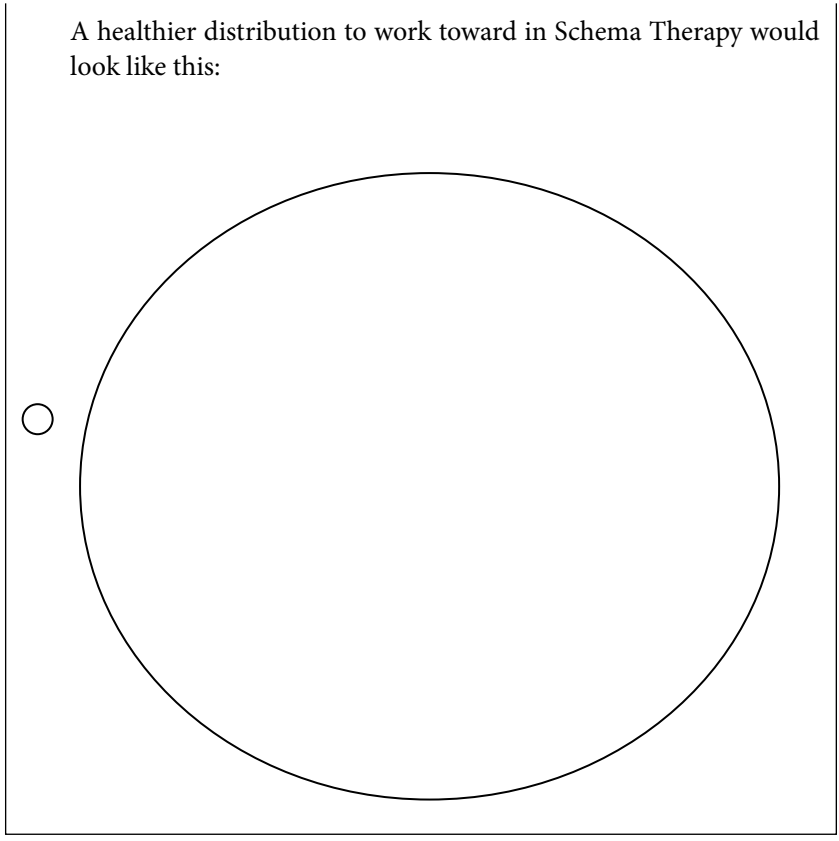
- Engage in playful activities such as games and puzzles. Be interested and get satisfaction from hobbies.
- Have outlets for creative impulses and expressions.
- Learn to be playful with others and increase laughter



Homework

A picture of my mode distribution today: draw lines to represent the approximate size of the six modes or parts of yourself):





Session 4 of ST Education describes the main interventions used in ST. ST integrates cognitive, experiential, and behavioral pattern-breaking work and this integration is one of the unique features of the model. Patients tend to be familiar with cognitive and behavioral interventions, so the focus here is on the experiential interventions and the work that integrates the three. Work with imagery, including imagery rescripting, is explained and discussed. We use an exercise that demonstrates to patients that they are able to "do imagery" and that it is not a painful or overwhelming experience. This is described in detail in the therapist notes for this session.

Session 5 focuses on the HCM. Learning about the modes continues, using games as the vehicle. These are described in the therapist notes.

By the last session it is important to have developed some easiness in talking about the modes and patients' interest in learning about their own modes. This helps to remove a sense of blame or being "bad" for having

mode experiences and provides a less psychopathology-oriented way of viewing themselves. They begin to understand that people around them are in various modes all the time, whether they have psychological diagnoses or not. This approach also facilitates universality, an important therapeutic factor that ST groups want to foster.

Schema Therapy Education Session 4: Schema Therapy

Your schemas and modes are identified through:



- discussing your childhood experiences;
- questionnaires about your usual behavior and feelings;
- imagery exercises in which modes are activated;
- noticing when schemas or modes get activated in contact with your therapists, group members, or other people;
- *strong* emotional reactions often indicate the activation of an important schema or mode – times when your reaction seems bigger than the situation you are in, but is understandable in the context of your life experiences. These intense reactions may be fear, anger, or activation of a Coping Mode and can be used as clues in figuring out which schema was activated and which mode triggered.

Example:

_____

_____

_____

_____

Techniques of Schema Therapy

Schema Therapy includes cognitive, experiential, and behavioral techniques or methods. The main techniques are described below.

1. Cognitive techniques are methods that use our thinking and reasoning

- Pro and Con lists: what are the advantages or benefits and disadvantages or costs of my present mode?
- What cognitive distortions are operating to maintain my mode (e.g., all-or-none thinking, catastrophizing, mind-reading)?
- Dialogues between different modes. In groups these dialogues include therapists and peers playing the role of my mode behaviors and in individual sessions empty-chair work is used for me to take all my mode roles.
- Mode flashcards.
- Mode monitoring: recording times when you notice modes occurring.

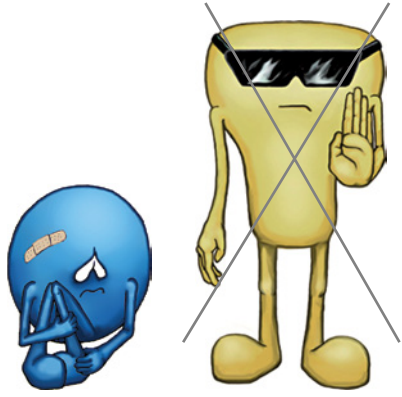
2. Experiential techniques are methods that help us to experience our emotions

Why is that necessary?

The Vulnerable Child Mode holds the painful emotions and memories from situations that we refer to as "roots." When in the Vulnerable Child Mode, you may or not have a conscious memory of the root situation. You may just be aware of scary or painful feelings. Memories do not always come to us in the form of specific details of a painful experience. Sometimes we only get the feeling part of a memory and we don't know what situation in the past it is connected to. This happens when root experiences of basic needs not being met or abuse or neglect occurred at a very young age. Memory research suggests that we may not reliably store complete accurate memories of events with details of the content until after age 6. In addition, if the event had an intense emotion as part of it, that can interfere with the memory content being stored also. So don't think that there is something wrong if you cannot easily identify roots right away. If the event was before you were talking, it will not be stored verbally.

We are asking you to be aware of the "root" experiences of modes so that your Healthy Adult Mode will be able to construct psychological antidotes – soothing and comforting experiences for your child part so that he/she can heal and you can move forward to a healthier happier life.

What happens in imagery exercises?



- In imagery exercises you will often end up in the mode of the Vulnerable Child and that is important! That is the mode that needs to be accessed to heal.
- Coping Modes automatically try to prevent the feeling of pain and hurt: that is helpful, in extreme or emergency situations, but not during imagery exercises or in therapy sessions!

How do imagery exercises work?

- They deliberately create as completely as possible an experience that your therapists describe to you.
- You close your eyes and let the image come to mind, try to see it with your mind's eye.
- Use language that is present tense, first person ("I am …," "I see …").
- Describe the picture in as much detail as you can, as if it is a scene in a movie that is running before your mind's eye.
- Try to experience the pictures as if you were really there (scents, tastes, noises).
- What do the people in this "movie" think, feel, and experience?
- Afterwards you can talk to your group or your individual therapist about the experience.
- We do not ask you to relive painful experiences. Our goal is to stop in an image before anything bad happens and change the ending to what should have happened to meet your child part's needs.

3. *Behavioral techniques are methods to break our old habits and develop new skills*

It is unfortunately *not* enough to:

- do the cognitive part of the work and change your thinking;
- or even to do the experiential part of the work so that your emotions change.

The goal of Schema Therapy



- Only by replacing your mode driven unhealthy behaviors and patterns with healthy adult skills can you fully realize the positive effects on your life from the changes that you make in psychotherapy.

Schema Therapy is unique as a treatment because it includes all of the three necessary components to make significant positive changes in your life. We think this is why research on Schema Therapy is demonstrating such big positive changes in people's psychiatric disorders and improvements in the quality of their lives.

Schema Therapy Education Session 5: Identifying Modes

1. "What's My (Mode)?" Game



We are going to play a game to give you practice in identifying modes. It is like the old US TV game show where people of different occupations come in and the panelists ask them questions to try to guess their occupation. In our game, it will be the *mode* the person is in that you will try to guess. The whole group will be panelists who can ask the players who, what, where, when, why. And watch the contestant group member answer questions in a *mode*. They cannot ask specific questions about the mode, but they can ask anything else – for example, "Did you have a lot of friends as a child," "What is your favorite activity," and so forth. There are cards with question suggestions.

2. Movie clips

Try to identify the modes that characters in the movie clips that we show you are in. If you are not sure, feel free to guess …

Movie clip 1

I saw the following behaviors and physical reaction:

_____
_____
_____
_____

I believe the person felt and thought:

_____
_____
_____
_____

The person could be in the following mode: _____

_____

Movie clip 2

I saw the following behaviors and physical reaction:

_____
_____
_____
_____

I believe the person felt and thought:

_____
_____
_____
_____

The person could be in the following mode: _____

_____

Movie clip 3

I saw the following behaviors and physical reaction:

_____
_____

I believe the person felt and thought:

The person could be in the following mode: _____

Movie clip 4

I saw the following behaviors and physical reaction:

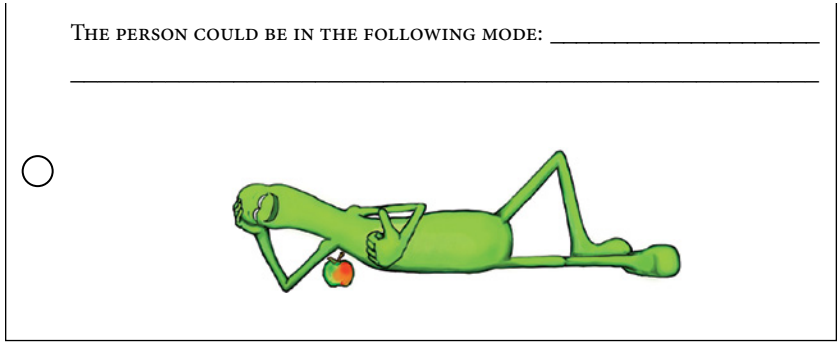
I believe the person felt and thought:

The person could be in the following mode: _____

Movie clip 5

I saw the following behaviors and physical reaction:

I believe the person felt and thought:



4.4 The 12 Mode Awareness Sessions

After the introduction to the concept of modes in the ST Education group, patients must learn to be aware of their own modes in daily life. Awareness has a cognitive component ("What am I thinking?"), an emotional component ("How am I feeling?"), a physiological component ("Can I notice any changes in my body?"), and a behavioral component ("What action(s) do I take?"). The goal of these sessions is to make patients aware that a mode has been triggered before they act. The first six sessions focus on awareness of the cognitive, emotional, and physiological components of modes, their current trigger situations, and the past experiences the mode is linked to. The second six sessions focus on using awareness for mode-change work. One of the ways the Mode Awareness group teaches patients about modes is from seeing and hearing about examples of other patients' mode experiences. For this purpose they are asked to complete Mode Awareness Assignment 1: Awareness of My Maladaptive Coping Mode (MA 1-MCM1) before the first session. Patients are given this handout at the end of the last ST Education session.

These sessions facilitate awareness of the HAM, the cognitions, feelings, and skills needed to meet the need present underneath the mode: for example, to replace a dysfunctional mode with healthier coping behavior. In the second cycle of Mode Awareness sessions the focus is on using awareness to change mode behavior.

Sessions 1–4 of Mode Awareness each begin with the discussion of a handout that presents examples related to the mode under focus. Providing examples reduces patients' fear of "getting it wrong" or "being stupid," facilitates more accurate understanding of assignments, and increases the likelihood that they will be completed. The example identifies the situation that triggered the mode, the associated thoughts,

feelings, and physical reactions, the need underlying the mode, and the connection of the current experience to childhood memories of similar experiences. If patients cannot identify any associated childhood memories, we focus instead on the underlying need. Be aware that the inability to recall childhood memories could be the result of an avoidant coping mode or could indicate that the memory underlying the mode goes back to a preverbal stage of development. In this case, the need underlying the coping modes would be safety. It is important to avoid producing memories to fill the gap.

Session 1 focuses on the MCMs. To allow for the considerable differences that are possible in patient groups, we did not specify which MCM. Patients can simply write in their mode, referring back to the ST Education material if needed.

Session 2 focuses on the Dysfunctional Parent Modes (Punitive Parent Mode and Demanding Parent Mode). We provided two handouts for this session, version a focusing on Punitive Parent Mode and version b focusing on Demanding Parent Mode. If the patients in your group have more difficulty with one of these two modes, focus on that mode. When making the connection to childhood experiences, you can get an idea of which important figures in a patient's life a DyPM is connected to. This is an example of the kind of information that it is important to share with the other therapists, particularly the patient's individual therapist.

Session 3 focuses on the VCM. The ST concept of Vulnerable Child varies somewhat, based upon the feelings present and the nature of the missed childhood need that creates the vulnerability. The example on the handout focuses on a lonely VCM, but you can substitute another example if the primary emotion your patients experience is different, for example an ashamed or a fearful/abandoned VCM.

Session 4 focuses on the ACM. For the ACM it is especially helpful if patients learn to be aware of physical signals such as heat waves, hot head, agitation, tense muscles, clenching the jaw, and so on. When a patient is in his/her ACM it is usually difficult to think, so physical signals are particularly helpful to use as awareness cues.

Session 5 focuses on the HCM and the handout changes a bit. Patients with psychological difficulties often have difficulty allowing themselves to experience the HCM. For this reason, in the handout we look at the modes that interfere with experiencing the HCM. Negative childhood memories may be associated with the interfering modes. In rare cases in patient populations, positive childhood memories come to mind and these can be shared.

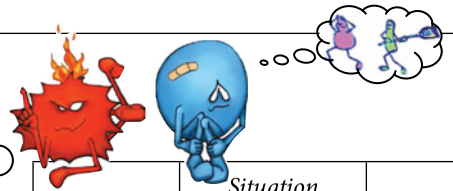
Management Awareness Assignment 1:
Awareness of My Maladaptive Coping Mode



Day	*Situation* *What situation were you in?*	*Thoughts*	*Feelings*	*Physical*	*Need and Mode*	*Childhood memories related to situation*
Example	Group discussion	I don't understand what they are talking about. I am just too stupid. I can't let anyone realize how stupid I am.	I feel too vulnerable, I am scared.	I am getting spacey, I don't feel my body.	To not feel overwhelmed, to feel safe Detached Protector	It is connected to elementary school when the other kids bullied me and said I was stupid. I had these feelings back then also.
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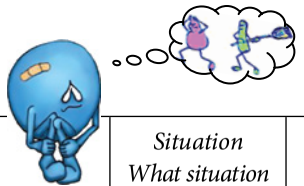


Mode Awareness Assignment 2a:
Awareness of My Punitive Parent Mode

Day	*Situation* *What situation were you in?*	*Thoughts*	*Feelings*	*Physical*	*Need*	*Childhood memories related to situation*
Example	I had a job interview and did not get the job.	I thought – I am a failure, I will always be a loser.	I felt shame, self-hatred, and disgust.	I feel sick to my stomach.	I need somebody to tell my Punitive Parent to shut up. I need somebody to tell me that going to an interview is a big step for me and that I did a good job in it even if I was not hired.	It is connected to my kindergarten teacher telling me I was a bad, stupid kid and that I was too clumsy to even tie my own shoe laces.
Monday						
Tuesday						
Wednesday						

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Saturday						
Sunday						





Mode Awareness Assignment 2b:
Awareness of My Demanding Parent Mode

Day	*Situation* *What situation were you in?*	*Thoughts*	*Feelings*	*Physical*	*Need*	*Childhood memories related to situation*
Example	I had to clean my room.	I think it has to be perfectly clean or it doesn't make sense to start at all. My thoughts are racing.	I felt under pressure. I can't name one feeling.	My whole body is tense. I start feeling dizzy.	I need someone to tell me to only do the basics – vacuum, take out the garbage, wipe the kitchen counters, and clean the toilet today. That is a lot so then I should rest. I can choose four more tasks for tomorrow.	It is connected to my mother who always modeled for me being the perfect housewife and never allowing yourself to rest.
Monday						
Tuesday						

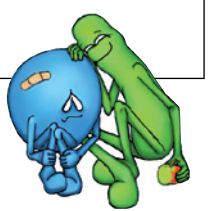
Wednesday						
Thursday						
Friday						
Saturday						
Sunday						



Mode Awareness Assignment 3:
Awareness of My Vulnerable Child Mode

Day	*Situation* *What situation were you in?*	*Thoughts*	*Feelings*	*Physical*	*Need*	*Childhood memories related to situation*
Example	I was in my room. My friend called and canceled our visit.	I think, she doesn't like me any more.	I feel vulnerable and sad.	I cry. Shaky feeling in my stomach.	To not feel alone.	It is connected to being left alone frequently when mom went to work.
Monday						
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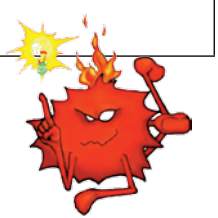




Mode Awareness Assignment 4:
Awareness of My Angry Child Mode

Day	*Situation* *What situation were you in?*	*Thoughts*	*Feelings*	*Physical*	*Need*	*Childhood memories related to situation*
Example	I had to make an important appointment. I knew this was stressful and difficult for me, but my friend told me I was exaggerating.	I think: I hate you! I am never going to tell you anything again!	I feel really angry.	My head feels hot. My jaw is tense.	I want my friend to understand that this is difficult for me and I want her to support me.	It is connected to my family telling me I shouldn't be so sensitive about everything. It felt like they were telling me that I was wrong or my feelings were wrong.
Monday						
Tuesday						
Wednesday						

Thursday						
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Sunday						





Mode Awareness Assignment 5:
Awareness of My Happy Child Mode

Day	*Situation* *What situation were you in?*	*Thoughts*	*Feelings*	*Physical*	*Interfering modes (remember: your needs are met currently)*	*Childhood memories related to situation*
Example	My roommates ordered pizza and asked me if I wanted to join them to eat pizza and watch a movie.	I think: Yippie!	I feel happy.	I smiled. I had a warm feeling in my gut. I couldn't hold my hands still.	Demanding Parent Mode tells me that I should do my group assignment first.	It is connected to my friends asking me to play with them and my father telling me that I couldn't go because I hadn't cleaned my room and that I was lazy to want to play first.
Monday						
Tuesday						

Wednesday						
Thursday						
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Therapist Notes: Mode Awareness Groups 1–6

What follows is a sample script for how we present the Mode Awareness work to patients. This sample session is for the Maladaptive Coping Modes. In sessions 2–5 you will be presenting material in a similar way for each of the other main modes. You can use the same sample script and substitute the mode your session is on. We have also provided some therapist tips for dealing with issues that frequently arise in these sessions.

○ *"Hello, I am glad that you are all here and I am happy to see you. This is the Mode Awareness group and in the sessions of this group we will focus on increasing your awareness of when you are in a mode; in other words – how you can monitor your modes. But before we start, we would like you to feel your feet on the floor, take a few deep breaths, and pull your attention to being here in the group with us all.*

You were given a worksheet to record your mode monitoring on three times a day.

We focus on one mode at a time. Whichever mode we are focusing on will be the main emphasis in your three groups and your individual session. Today we are focusing on the Maladaptive Coping Modes (fill in the group of focus here). *So today we will focus on situations when you were in this mode. We will start by going over an example together."*

Give them the Mode Awareness handout for the session. Here you go over the example in detail, answering patients' questions and facilitating group members involvement in the discussions. What follows is an example of how we present the examples.

○ *"Imagine that you are in a group session and there is a discussion. If you are in the Maladaptive Coping Mode, you might think: "I don't understand what they are talking about. I am just too stupid. I can't let anyone realize how stupid I am." You might notice that you are getting spacey and don't feel your body anymore. Behind the "mask" of the Maladaptive Coping Mode you might feel too vulnerable and scared and have the need to not be overwhelmed and to feel safe.*

Does anyone recognize the experience of any of these feelings, thoughts, or physical sensations when in the Maladaptive Coping Mode?"

Acknowledge everyone who indicates recognizing any of these feelings, thoughts, or physical sensations when in the Maladaptive Coping Mode. Head nodding should also be acknowledged in order to shape their participation. It can take patients some time to talk in group, so it is important to encourage their participation by reinforcing small steps, including nonverbal involvement.

> *Our current experiences can have connections to past experiences that are similar. For example, the experience of being in the group could be connected to a memory of another experience of being in a group – for example, in elementary school being bullied by other kids. This kind of connection between present experience and a painful memory can cause your feelings and reaction in the present to be "bigger." It is as if you are not just reacting to feelings about being in this group now, but also to the bullying memory.*

> *Does that make sense to you?* [If someone says "no":] *Do you know which part was not clear?* [Try to clarify or ask another group member to summarize in their words.]
>
> *Do you have any questions?* [Go through all their questions.]
>
> *Did any of you experience a Maladaptive Coping Mode on Monday? Let's go through your situation.*
>
> [Do this for all days of the week. Let patients volunteer and then rotate, asking the rest to give an example so that everyone who wants to has a turn to speak.]

> [Group ending:] *Great work today, everyone. Here is the worksheet for next week.* [Give them the Mode Awareness 2 worksheet and the weekly monitoring sheet.] *This is the assignment for next week. It would be great if you could try to monitor your Vulnerable Child Mode from today on, and try to fill in the spaces on the worksheet. If you have questions or need help, you can ask the nurses or your individual therapist, if we are not available.*
>
> *We were very happy to have you here.*
>
> *Goodbye – have a good rest of your day.*

This script, with minor adjustments for content and to fit your group and style, can be used for Mode Awareness Assignments 2–6.

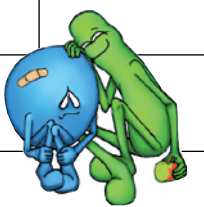
Sessions 6 and 12 focus on the HAM. The handout for these sessions (Mode Awareness Assignments 6 and 12: Accessing My Healthy Adult Mode (MA 6&12-HAM1&2)) focuses on changing mode behaviors. We try to shift the focus now to the adaptive modes a patient has and try to increase their awareness of the HAM behaviors in their repertoire. By the time these sessions take place, if you are following the recommended sequence of the groups, patients will have had some of the Mode Management and Experiential Mode Work sessions. Those sessions will have provided them with tools to use to change maladaptive or dysfunctional mode behavior. First, patients are asked to decide which mode they want to work on and to describe that mode in awareness terms. Next, they are asked to create a situation that could trigger the chosen mode. The ST Education handouts where patients recorded situations that trigger certain modes can be used for reference. After a specific trigger situation is decided upon, a "Good Parent point of view" is developed. We conceptualize "Good Parent" as one part of HAM, a part that always has a caring attitude and a positive view of the child modes and can understand the origin and original survival function of our MCMs. The "Good Parent point of view" is often one that patients have and use when dealing with others, particularly children, but do not apply to themselves. We see identifying the presence of this attitude toward others as an interim step toward being able to use it for themselves. We see this "Good Parent" attitude as part of the HAM – the part that can care for their VCM. After the Good Parent point of view is identified, a plan of action from the Healthy Adult point of view can be developed and the skills needed to act on the plan are identified. Positive results expected from the plan and any potential difficulties or negative consequences can be discussed. We want patients to start planning how they will change dysfunctional modes in specific situations. We encourage them to be proactive in their planning, rather than waiting for appropriate situations to appear. The handout for this session can also be used in IST to develop behavioral experiments for mode change.

Sessions 7, 8, and 10 have the same focus – using awareness of HAM skills to get out of problematic modes: MCMs (session 7; handout – Mode Awareness Assignment 7: Connecting with My Healthy Adult from My Coping Mode (MA7-MCM2)), DyPMs (session 8a for Punitive Parent Mode and 8b for Demanding Parent Mode; handouts – Mode Awareness Assignment 8a: Letting My Healthy Adult Mode Banish My Punitive Parent Mode (MA8a-DyPM2) and Mode Awareness Assignment 8b: Letting My Healthy Adult Convert My Demanding Parent to Reasonable Standards (MA8b-DyPM2)) and the Angry or Impulsive Child Modes (session 10; handout – Mode Awareness Assignment 10: Enlisting My Healthy Adult to Listen to the Needs

Mode Awareness Assignments 6 and 12: Accessing My Healthy Adult Mode

Day	*Mode to work on Which mode are you trying to work on? Maladaptive Coping, Punitive or Demanding Parent, Vulnerable Child, Angry Child*	*Awareness of the mode Thoughts? Feelings? Physical? Underlying need?*	*Planned situation In which situation can your Healthy Adult work on this mode?*	*Good Parent point of view What are facts and alternative interpretations?*	*Plan of the Healthy Adult Mode What is your plan??*	*Skills of the Healthy Adult Mode Which skills can your Healthy Adult Mode use so that your plan works?*	*Consequences Did the plan work?*
Example	Vulnerable Child	I think nobody likes me. I feel sad. I cry and hide in my room.	I can work on this mode after I have a discussion with someone as I always feel lonely afterward.	It is OK to be sad when you have a discussion with somebody you like and you can't reach an agreement. That doesn't mean that nobody likes you anymore. Lots of people like you and I do.	I plan to call one of my other friends to feel connected to someone.	I can do a pro/con list for the question of making a phone call. I can consider who would be good people to call. I can imagine what my therapist would say to motivate me to connect to friends when I feel lonely.	My plan worked. I imagined what my therapist would say to motivate me and after that I called a friend. After the phone call I didn't feel lonely.

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of My Angry Child (MA10-ACM2)). The handout-assignment for these sessions is similar to the one for the HAM (sessions 6 and 12). The patient is asked for: situation, need, awareness, Healthy Adult point of view and skills, and consequences. Again, it is up to the therapists in these sessions to choose the specific mode to work on, based upon their patients.

Session 9 applies the HAM skills for the VCM. The handout (Mode Awareness Assignment 9: Enlisting My Healthy Adult to Care for My Vulnerable Child(MA 9-VCM2)) distinguishes among the different versions of the VCM as different skills work for different nuances of feelings such as sadness, fear, loneliness, shame, and so on. It is helpful here to refer to the Mode Management group plans that were developed.

Session 11 focuses on mode interference with the HCM and using HAM skills to access the HCM (handout – Mode Awareness 11: Letting My Healthy Adult Mode Learn About My Identity by Listening to My Happy Child Mode (MA 11-HCM2)).

Session 12 is the same as Session 6.

4.5 The 12 Mode Management Sessions

The primary focus of this group is developing an individualized **Mode Management Plan (MMP)**. This is a plan that lists the patient's personal set of cognitive, behavioral, and experiential strategies to use to counter maladaptive modes that are triggered. The MMP is prepared in flashcard or other accessible form. Some of our inpatients made very small cards connected by string to keep attached to their notebooks or purses so that they were constantly available. MMPs engage the HAM from which patients are able to get their needs met in an adaptive and healthy way and fulfill the necessary functions to have a happy life. In the Mode Management component we have included a section on experiential skills a patient could use in certain situations. **Experiential Mode Work (EMW)** is a separate group, but disentangling the three types of skills is difficult and somewhat arbitrary as there is overlap. The main difference is that in the EMW sessions the focus is on change through therapist-guided experiential interventions in the moment, which provide corrective emotional experiences. The experiential techniques of this component focus on the patient's ability to use the experiences in the EMW group, particularly imagery and recalling rescripted images.

Session 1 of Mode Management is focused on the MCMs. The goal for coping modes in ST is not to get rid of them completely, but to be aware of when they are triggered and to be able to make a choice about whether the old response will get your need met in the current situation or a different coping strategy is needed. An MCM can have a number of different coping



Mode Awareness Assignment 7: Connecting with My Healthy Adult from My Coping Mode

Day	*Situation What situation were you in?*	*Need and underlying mode*	*Awareness Physical and emotional awareness? Thoughts?*	*Healthy Adult point of view What are your ideas? Keep your Good Parent in mind. What choices do you have?*	*Healthy Adult skills Try a cognitive, behavioral, or experiential technique*	*Results Record any effects the skill had, negative and positive. Did you flip to another mode?*
Example	Group discussion	To not feel overwhelmed, to feel safe (Vulnerable Child Mode).	Getting spacey, don't feel body. I want to get away.	Group has been safe. I can detach or stay present.	Use safety-bubble	I chose to use the safety-bubble. I was able to stay in group and learned about the pros and cons of the Detached Protector Mode.
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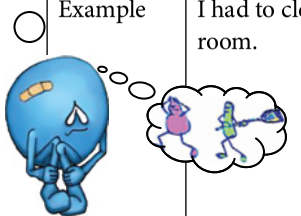
Mode Awareness Assignment 8a: Letting My Healthy Adult Mode Banish My Punitive Parent Mode

Day	*Situation* *What situation were you in?*	*Need and underlying mode*	*Awareness* *Physical and emotional awareness?* *Thoughts?*	*Healthy Adult point of view* *What are your ideas? Keep your Good Parent in mind. Which choices do you have?*	*Healthy Adult skills* *Try a cognitive, experiential, or behavioral skill.*	*Consequences* *Record any effects the skill had.* *Did you flip to another mode?*
Example	I had a job interview and did not get the job.	I need somebody to tell my Punitive Parent to shut up and to tell me that going to an interview is a big step for me and that I did a good job in there. (Vulnerable Child Mode)	I felt ashamed and guilty. I thought that I am a loser. I felt sick to my stomach.	I did not get the job. But I made it to the interview. I can give up or I can try to get more interviews.	I told my Punitive Parent to shut up. I also told myself that going to an interview is a big step for me and that I did a good job there. I imagined how it felt when I got the invitation letter for the job interview.	I felt less like a failure. My Punitive Parent did not shut up, but was not as loud. I switched into my Vulnerable Child Mode, but I managed to soothe myself and then I was able to send another job application in.
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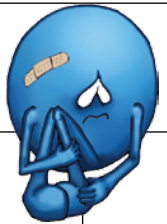
Mode Awareness Assignment 8b: Letting My Healthy Adult Convert My Demanding Parent to Reasonable Standards

Day	*Situation What situation were you in?*	*Need and underlying mode*	*Awareness Physical and emotional awareness? Thoughts?*	*Healthy Adult point of view What are your ideas? Keep your Good Parent in mind. Which choices do you have?*	*Healthy Adult skills Try a cognitive experiential, or behavioral skill.*	*Consequences Record any effects the skill had. Did you flip to another mode?*
Example 	I had to clean my room.	I need help and protection from the unrelenting standards of my Demanding Parent Mode.	I felt under pressure. My thoughts were racing.	I need to wash my clothes so I have something to wear. I can do the rest of the cleaning later or another day. Or I can do it all and it will take a long time.	I imagined a good, supportive parent, who told me to do only the necessary part of the job today and take a rest after that.	I felt less under pressure. I did one load of laundry. Then I took a rest. I think that when I allow myself to take breaks, it makes it easier for me to pick the work up again.
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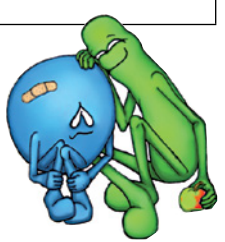




Mode Awareness Assignment 9: Enlisting My Healthy Adult to Care for My Vulnerable Child

Day	*Situation* *What situation were you in?*	*Need*	*Awareness* *Physical and emotional awareness?* *Thoughts?*	*Healthy Adult point of view* *What are your ideas? Keep your Good Parent in mind. Which choices do you have?*	*Healthy Adult skills* *Try a cognitive, experiential, or behavioral skill.*	*Consequences* *Record any effects the skill had.* *Did you flip to another mode?*
Example	I was in my room. My friend called and canceled our visit.	To not feel left alone.	I feel vulnerable and sad. I cry. I think, she doesn't like me any more.	She did call and say she had to work. She has not lied to me before. I can hide in my room or do something soothing.	I can have a hot chocolate to soothe myself. I can then call her to reschedule her visit. I can revisit the image of her telling me that she cares about me.	I was able to experience disappointment safely. I managed to calm myself down and call my friend. She said she would visit on Saturday and that she was sorry she had to change plans.
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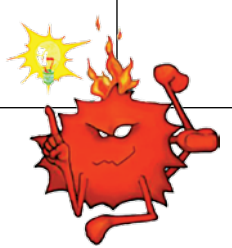




Mode Awareness Assignment 10: Enlisting My Healthy Adult to Listen to the Needs of My Angry Child

Day	*Situation What situation were you in?*	*Need*	*Awareness Physical and emotional awareness? Thoughts?*	*Healthy Adult point of view What are your ideas? Keep your Good Parent in mind. Which choices do you have?*	*Healthy Adult skills Try a cognitive, experiential, or behavioral skill.*	*Consequences Record any effects the skill had. Did you flip to another mode?*
Example	I had to make an important appointment. I knew that was difficult for me, but my friend told me I was exaggerating.	To be understood and validated.	My head feels hot. I am really angry. I want to yell at my friend.	I want my friend to understand that this is difficult for me and I want her to support me. I can yell at her now or try to vent my anger elsewhere and then talk about the problem.	I can go to my room and hit my pillow to vent my anger. I can then go back to my friend and tell her that the situation might be more difficult for me than for her, because of my history, and that it would help me if she would support me during the phone call.	My friend listened to me when I told her what was going on. She even said she would help me. Then my Punitive Parent Mode came and said I was so stupid to need help with everything. That was difficult.

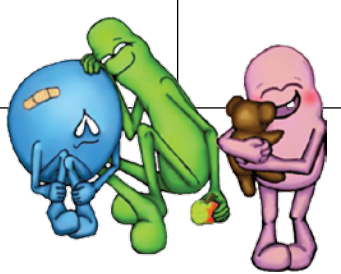
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Mode Awareness Assignment 11: Letting My Healthy Adult Mode Learn About My Identity by Listening to My Happy Child Mode

Day	*Situation* *What situation were you in?*	*Awareness of Happy Child Mode* *Thoughts? Feelings? Physical? Childhood memories?*	*Interfering modes* *Which modes made it difficult for your Happy Child mode? How did they do it?*	*Healthy Adult point of view* *What are your ideas? Is this a situation in which you can stay in Happy Child Mode? If yes, how can you deal with the interfering modes?*	*Skills of the Healthy Adult Mode* *Try a cognitive, behavioral, or experiential skill to find your way back to your Happy Child Mode.*	*Consequences* *What have you learned about yourself and your identity?*
Example	My roommates ordered pizza and asked me, if I wanted to join them to eat pizza and watch a movie.	I thought: Yippie! I feel happy and can feel a smile appearing on my face when they ask. I had a warm feeling in my belly. I couldn't hold my hands still. I imagined myself with a big slice of pizza, sitting on the couch with the others and laughing about the movie. I remembered how it felt to laugh when playing with my cousins when I was little.	My Demanding Parent Mode told me that I should do my homework first ("First the duties, then the fun"). Then my Demanding Parent Mode said that pizza is unhealthy and makes me fat. Then my Punitive Parent Mode started to come out too.	I have the whole morning tomorrow to do my homework. And I know that I can't eat pizza every day because it would be unhealthy, but it is OK to eat it once in a while and I won't become fat from that. I believe it is OK to stay in Happy Child Mode.	I imagined the moment when my roommates asked me to join them and focused on the warm feeling in my belly and the picture of us on the couch with the pizza and the funny movie.	I went over and had fun with them, ate pizza, and watched the movie. I learned that I can have fun with them, that I like eating pizza and watching funny movies with others. I feel happiness when I do these things.

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Therapist Notes: Mode Awareness Groups 7–12

What follows is a sample script for how we present the second half of the Mode Awareness work to patients. This sample session is for the Vulnerable Child Mode, which is session 9. In the other sessions in 7–12 you will be presenting material in a similar way for each of the other main modes. You can use the same sample script and substitute the mode your session is on. We have also provided some therapist tips for dealing with issues that frequently arise in these sessions.

> *Hello, I am glad that you are all here and I am happy to see you. This is the Mode Awareness group. In the first set of sessions when we went over one mode at a time we focused on increasing your awareness of your experience of each mode. In this second set of sessions we focus on how you can enlist the aid of your Healthy Adult Mode to meet the needs of, or manage, the maladaptive or dysfunctional modes as well as strengthening the adaptive or healthy modes.*
>
> *But before we start, we would like you to feel your feet on the floor, take a few deep breaths and pull your attention to being here in the group with us all.*
>
> *You were given a worksheet to record your situations and your awareness of the HAM point of view and HAM skills. In addition you were asked to record the results of using your HAM which we will review today.*
>
> *As you know by now, we focus on one mode at a time. Whichever mode we are focusing on will be the main emphasis in your groups and your individual session. Today we are focusing on the* Vulnerable Child Mode (fill in the group of focus here). *So today we will focus on situations when you were in this mode. We will start by going over an example together.*

Give them the Mode Awareness handout for the session. Here you go over the example in detail, answering patients' questions and facilitating group members' involvement in the discussions. What follows is an example of how we present the examples.

> *Take a look at the worksheet now. Let's go through the example together. Imagine you were in your room and your friend called and cancelled a visit. If you were in the Vulnerable Child Mode, you might think that your friend doesn't like you anymore, you might notice that you have a shaky feeling in your stomach and that you start crying. You might feel vulnerable and sad and have the need to not be left alone.*
>
> *Does anyone recognize the experience of any of these feelings, thoughts, or physical sensations when in the Vulnerable Child Mode*?

○ Acknowledge everyone who indicates recognizing any of these feelings, thoughts, or physical sensations when in the VCM. Head nodding should also be acknowledged, but at this point in treatment you could ask for a verbal response also by saying something like "*Can you tell us a little about your experience?*" If you have someone new to the group, also acknowledge that.

> *Now let's look at the last three columns. The first of them is the "Healthy Adult point of view." What ideas about how to deal with this situation do you have from your "Healthy Adult point of view"? Consider what you think a "good parent" would suggest. What choices do you have? Let's look at the ideas in the example. The person could evaluate how this friend has behaved in previous situations. She can think about the choices she has – for example, she can hide in her room or soothe herself. Do you have any other ideas about what the person could think about or other actions to take?*

○ Go through different ideas and alternatives they mention and evaluate with them whether those alternatives could work and any possible negative consequences of the actions they suggest.

> *The next column focuses on cognitive, behavioral, or experiential Healthy Adult skills. In the example, the person could have a hot chocolate to soothe him or herself. He/she can then call the friend to reschedule a visit. Do you have any other ideas about what the person could think about or do?*

Go through different cognitive, behavioral, and experiential skills they mention and evaluate with them whether these skills could work.

> *Does what we are doing make sense to all of you?* [If someone says "no":] *Do you know what is not clear?* [Try to clarify or ask another group member too summarize in their words.] *Do you have any questions?* [Go through all their questions briefly.]

> *The last column focuses on the results of the action taken. The person in our example was able to experience disappointment safely and managed to calm him or herself down. The friend said she would visit on Saturday.*
>
> *Sometimes as a result of using a Healthy Adult Mode skill a mode switch will occur. And that can mean that you have to use more Healthy Adult skills if the switch is to an unhealthy mode like the Punitive Parent Mode. In this example, it looks like the person could stay in Healthy Adult Mode.*

Review of their awareness monitoring

> *OK, now let's go over some of your experiences over the last week. Did any of you experience a Vulnerable Child Mode this week?*

Let patients volunteer and then rotate, asking the rest to give an example so that everyone who wants to has a turn to speak. The goal is to elicit one example from each of them.

Therapist Tip

It can be challenging in a group to balance the amount of time each patient uses without having your limit setting discourage future participation and worries about "*Oh dear, I might talk too much and have the therapist tell me that.*" We try to set up the situation from the start by saying things like: "I think we will have time for one example from each of you." "I'm very interested in what you have to say, but I am going to have you hold off for a minute until everyone has had a first turn." With the last example it is then important to get back to that person even if it is to say "I realize that we never got back to your example and now we are out of time. I'm sorry that happened – there often seems to be more for us to discuss than we have time for. Will you bring it up next week if it fits with what we are focusing on?" However, no matter how gently we try and how validating

we try to be, someone will be hurt or angry on occasion. When that happens, we look at it as an example of mode triggering and, if appropriate to the session content, we ask what mode it is and look at the childhood memories connected to it and whether it is a reaction based on the past as well as the present.

> *Great work today, everyone. Here is the worksheet for next week and your monitoring form. Just read over the worksheet and we will go through it in detail in next week's Mode Awareness group*. [Give them the next Mode Awareness worksheet and the weekly monitoring sheet.] *These are your assignments for next week. We would like you to try to monitor your Healthy Adult Mode dealing with your* [fill in the blank as appropriate] *from today on and try to fill in the spaces on the assignments*. [In the case of modes with more than one variation: *We gave you two exercise sheets, one for the Punitive Parent Mode and one for the Demanding Parent Mode* (or Maladaptive Coping Modes). *You can alternate the two handouts if you experience both modes, or you can just focus on one of them if you like*.] *If you have questions or need help, you can ask the nurses or other staff or your individual therapists, if we are not available*.
>
> *We were very happy to have you here. Goodbye – have a good rest of your day*.

This script, with minor adjustments for content and to fit your group and style, can be used for Mode Awareness sessions 7–12.

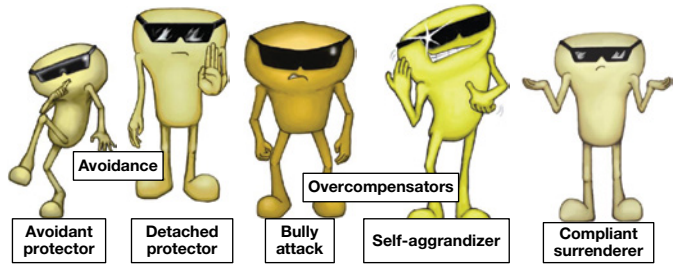
strategies. In many cases the problem is not the use of the coping strategy itself, but the excessive use of one (i.e., sometimes we can choose to avoid a certain confrontation, but it is not useful if we always avoid all confrontations). Other coping strategies may regularly have negative effects and need to be eliminated (i.e., taking illegal drugs). The MCMs are survival measures intended for use in extreme threatening situations (i.e., fight, flight, or freeze). The problem our patients have is that they are using them in everyday situations that are not actually survival threatening but feel that way because they are linked to childhood situations when survival was at risk because core needs were not met. We label these coping strategies MCMs because they do not fit the current life situation and they do not

serve effectively to get needs met. For survival situations they may be needed and can be held in reserve for that purpose, just not for everyday use as their effects are extreme and they can be exhausting.

Session 1 starts with a short introduction on MCMs and ST's goal regarding these modes. Then we employ an experiential exercise that asks patients to imagine a situation in which they hear a message from an MCM (Mode Management Session 1: Reducing the Power of the Maladaptive Coping Modes (MM 1-MCM1)). This is done to make patients more aware of the mode. We then ask patients what their HAM could say to their MCM in that situation. After that, we work on behavioral and cognitive skills to use with MCMs in the short term. By "in the short term" we mean that we focus on skills that will help a patient immediately once he/she notices that an MCM has been activated.

Mode Management Session 1: Reducing the Power of the Maladaptive Coping Modes

All Maladaptive Coping Modes developed to try to protect your Child Modes from feeling emotional pain. This emotional pain can be from outside (other people) or from inside (your own Dysfunctional Parent Modes).



Our goal is to help you to reduce whichever variations of the Maladaptive Coping Modes you have with the help of your Healthy Adult Mode. We don't want to get rid of them completely, since they are needed from time to time in survival situations. When these modes get too powerful, they can become automatic ways of coping that take control over you, and you lose the ability to use Healthy Adult coping strategies for non-emergency situations, other people, or even your other modes.

The bottom line is that we want you to be able to make a choice about which coping strategy will get your need met in the situation you are in now. We want to help you develop strategies

to handle these old Maladaptive Coping Modes, when you feel that one is taking over control.

Imagine a situation in which you hear a message from your Maladaptive Coping Mode.

What can your Healthy Adult Mode say to your Maladaptive Coping Mode?

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Reducing Your Maladaptive Coping Modes: Short-Term Behavioral and Cognitive Strategies

Make a list of things you can do and healthy thoughts, when you notice that you're stuck in your Maladaptive Coping Mode and it is not getting your need met. Today we will be looking at short-term, more immediate strategies. The next time we work on this mode we will focus on strategies for the long term to reduce the grip of this mode.

	Reducing Avoidant Protector	*Reducing Compliant Surrender*	*Reducing Overcompensation*
Example:	*My Avoidant Protector keeps me locked up in my apartment. I have an appointment with a new psychotherapist coming up that I really want to attend.*	*My Compliant Surrenderer stops me from telling my friend how I feel, when she cancels our dates via text-message, with very little notice.*	*My Overcompensator prevents my therapist from giving me the understanding I need, when I missed an important appointment with the job center, but I am being really sarcastic about it.*

	Reducing Avoidant Protector	*Reducing Compliant Surrender*	*Reducing Overcompensation*
Short-term behavioral strategies	*I could call a former co-patient who always supports me by telling me that I can make it.*	*I could call her immediately and tell her that it makes me upset when she does that. I could also tell her that when she cancels like this I worry that she might not want to be friends with me anymore. I could ask for reassurance and to agree on a new date.*	*I could tell my therapist that I can't talk about the reasons for missing the appointment yet, but that it's not because I didn't care about it. I could ask my therapist to remind me of similar situations where it helped me to talk about the difficulties I run into. I could also be reminded that she will not criticize or reject me.*
Your strategies:			
Example:	*My Avoidant Protector keeps me from going to a job interview.*	*My Compliant Surrenderer keeps me from studying for my final exams, after my new boyfriend told me I should study less and spend more time working to earn money*	*My Overcompensator keeps me from admitting mistakes I made.*

	Reducing Avoidant Protector	*Reducing Compliant Surrender*	*Reducing Overcompensation*
Short-term cognitive strategies	*I could think of 10 good reasons why it would be good for me to go and why nothing horrible can happen to me there.*	*I could think about exactly what will be tested on the exam. I could break it down into weekly schedules with study time and free time so it doesn't seem overwhelming. I could think about how to make it clear to my boyfriend that studying is important to me.*	*I could think about why I made the mistake and why I acted the way I did. I could realize that I didn't make the mistake on purpose and then think about how I could solve the situation next time.*
Your strategies:			

◯ **Reducing the Power of Your Maladaptive Coping Modes: Short-term Experiential Techniques**

In the Experiential Schema Therapy group we tried some techniques to get through Maladaptive Coping Modes on the emotional or experience-based level. We will try more of them over the course of this program. These techniques include the experiential focusing exercise, imagery rescripting exercises, mode dialogues, and others. Make a list of the experiential techniques you can use when you notice that you're stuck in one of your Maladaptive Coping Modes and it is not getting your need met.

Example:	*My Avoidant Protector keeps me from telling my social worker that I have started drinking again in the evenings.*	*My Compliant Surrender tells me to just go along with the exercise my therapist proposes and not tell her that this really scares me.*	*My Overcompensator makes me look really hostile when I meet new people.*
Short-term experiential techniques	*I can access my memory of her helping me last time I confessed that I had started drinking again. Unlike my parents, she did not yell at me, but told me that she would try to help me stop again. We poured out the rest of the alcohol together and made a plan for what I could do this evening.*	*I can imagine the first session we had together when she told my Compliant Surrenderer that she really wanted to be there for my Vulnerable Child and that she understands how important Compliant Surrenderer was for me in the past. I can remember that she also said that we can do therapy at my own pace and that made me feel really safe.*	*I can remember the Experiential Focusing Exercise in which I noticed that the Overcompensator comes up when people get too close to me too fast. I can also remember how it felt when I could walk towards them – and that this felt better for me, because I had more control. Maybe I can get out of my Overcompensator by allowing myself to control my physical closeness to new people and give myself time to check out whether I feel safe with them.*

Your strategies: 			

Short-Term Mode Management Plan for My Maladaptive Coping Modes

In this session we worked out short-term or immediate behavioral, cognitive, and experiential strategies and techniques that your Healthy Adult Mode can use to deal with different types of Maladaptive Coping Modes.

Below, make a Mode Management Plan with your *preferred strategies and techniques* for each of the Maladaptive Coping Modes that you experience. You can carry your plan with you as a flashcard or an emergency plan to support the changes you are working on.

Avoidant Protector	*Compliant Surrenderer*	*Overcompensator*
Add more techniques to your plan as you identify other strategies that work for you.		



Don't expect your Mode Management Plan to be final today or even in a few weeks. You can add new techniques as you discover them through treatment. We cannot tell you that your Mode Management Plan will work in every situation or 100%, because no one's does. What we can tell you is that it will work better or have fewer negative consequences than your Maladaptive Coping Modes. Mode Management Plans need to match specific kinds of situations and to be tested and fine-tuned. At the beginning you will probably need the help of your therapists, the treatment team, and your peers to add to your plan – but over time your Healthy Adult will internalize all of these healthy coping techniques and you will get better at accessing them and remember to use them more often.

Therapist Notes: Mode Management Groups 1–6

What follows is a sample script for how we present the Mode Management work to patients. This sample session is for the Maladaptive Coping Modes. In sessions 2–6 you will be presenting material in a similar way for each of the other main modes. You can use the same sample script and just substitute the mode of your session. We have also provided some therapist tips for dealing with issues that frequently arise in these sessions.

> *Hello, I am glad that you are all here and I am happy to see you. This is the Mode Management group. In the sessions of this group we will focus on specific skills you can use when you notice that you are stuck in a mode that doesn't meet your current need. But before we start, we would like you to feel your feet on the floor, take a few deep breaths, and draw your attention to being here in the group with us all.*

Here is the handout that we will work with today. We focus on one mode at a time. The mode we are focusing on will be the main emphasis in your groups and your individual session. Each session of Mode Management focuses on a different mode or set of modes – today it is the Maladaptive Coping Modes (fill in the group of focus here). *Now, remember there are different versions of Maladaptive Coping Modes (MCM) that people can experience. The problem with all these versions is that they take over instead of your Healthy Adult Mode (HAM) choosing a behavior that would be effective in the situation you are in today. So, we will work on strategies today to manage your MCMs. To start, let's all imagine a situation in which you were in an MCM. Does everyone have a picture?* [Wait about 1 min.] *OK, let's look at today's handout.*

Give them the Mode Management handout for the session. Collect what patients say. Reinforce statements by nodding or praising participation.

Look at the first question and think about the situation you just imagined. What could your HAM say to your MCM?

Great ideas. Let's write them down. Anything else? Yes, good, let's write it down, too ….

Here you go over the example in detail, answering patients' questions and facilitating patients' involvement in the discussion. What follows is a description of how we present the examples.

Now let's look at the next page. What we need is a list of short-term or immediate strategies when you notice that one of the MCMs has taken over. Today we will look at things that can help you immediately, when you get caught in an MCM. Next time we work on this mode we will focus on things you can do in the long term to reduce the frequency and strength of the mode and be able to access your HAM.

Let's go through the example for the Avoidant Protector:

"*My Avoidant Protector keeps me locked up in my apartment. I have an appointment with a new psychotherapist coming up that I really want to attend.*"

Has anyone experienced a situation like this?

Acknowledge everyone who indicates recognizing a situation like this when in the Maladaptive Coping Mode. Head nodding should also be acknowledged as it can take patients some time to talk in group, so it is important to encourage their participation by reinforcing small steps, including nonverbal involvement.

Alright, let's look at a behavioral skill to get out of that situation.

"*I could call a friend who always supports me by telling me that I can make it.*"

That is a good idea. Has anyone tried that? How did it work? That is really good. OK, what about other things you could do to get out of the situation, can anyone think of anything?

If your patients cannot think of other behavioral skills, give them suggestions like the Pro and Con list, listening to inspirational music while getting ready, taking your dog with you so you don't have to do it alone, and so forth.

Yes, those are great ideas. Let's write them all down, so you can pick from different coping strategies the next time you are in an MCM situation.
Let's look at the next example.

"*My Avoidant Protector keeps me from going to a job interview.*"

What could help you get out of the Avoidant Protector Mode with a cognitive skill, in this situation? The example suggests a reality check.

"*I could think of 10 good reasons why it would be good for me to go and why nothing horrible can happen to me there.*"

What other things can you think of or remind yourself of, if you are in an Avoidant Coping Mode?

If your patients cannot think of other cognitive skills, give them suggestions like the Pro and Con list, positive self-talk, and so forth.

> *I am glad you can think of so many things. That is good work. Let's write them all down, so you can pick from different coping strategies the next time you are in an MCM situation.*

Do this for all mode variations on the handout. Let patients volunteer and then rotate, asking the rest to give an example so that everyone who wants to has a turn to speak.

Next, you go over the Mode Management Plan for each patient in detail. What follows is an example of how we present the examples.

> *Now look at the last page. Here we want to develop a Mode Management Plan for your MCMs that you can use every day. Who has an Avoidant Coping Mode?* [Acknowledge people who are nodding. Choose one person.]
>
> *Is it OK if we start with you?* [Wait for OK.] *Which three techniques that we talked about today do you want to write down for your Mode Management Plan for your Avoidant Coping Mode?* [Do this for all patients who have an Avoidant Coping Mode.] *Who has a Compliant Surrenderer?* [Acknowledge people who are nodding. Choose one person.]
>
> *Is it OK if we start with you?* [Wait for OK.] *Which three techniques that we talked about today do you want to write down for your Mode Management Plan for your Compliant Surrenderer?* [Do this for all patients who have a Surrendering Coping Mode.]
>
> *Who has an Overcompensating Coping Mode?* [Acknowledge people who are nodding. Choose one person.]
>
> *Is it OK if we start with you?* [Wait for an answer.] *Which three techniques that we talked about today do you want to write down for your Mode Management Plan for your Overcompensating Coping Mode?* [Do this for all patients who have an Overcompensating Coping Mode.]

> [Group Ending:] *Great work today, everyone. So your* therapy assignment *from today's group is to monitor your Healthy Adult Mode dealing with your MCM from today until our next meeting and try to fill in some more of the spaces. Here is the worksheet for next week. We were very happy to have you here.*
>
> *Goodbye – have a good rest of your day.*

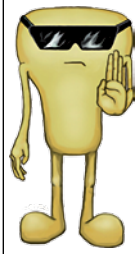
This script, with minor adjustments for content and to fit your group and your personal style, can be used for Mode Management sessions 2–6.

In **sessions 7 to 12** we work on long-term skills to manage each of the modes. These sessions are designed to help patients reduce the strength or frequency of a mode in the long term, but they do not necessarily help immediately. In session 7 we distinguish the three styles of coping: avoidant coping modes like Detached Protector and Compliant Surrenderer, and overcompensating coping modes like Bully-Attack and Self-Aggrandizer. First, example situations and a behavioral or cognitive skill are developed for every mode, then the same thing is done with experiential techniques for MCMs. On the last page of the handout for session 7 (Mode Management Session 7: Reducing the Power of the Maladaptive Coping Modes – Long-Term Strategies (MM 7-MCM2)), these strategies, techniques, and skills are organized into an MMP for each of the styles of MCM that the patient is working on. Patients record the cognitive, behavioral, or experiential skills that they want to try out in the coming weeks of treatment.

Mode Management Session 7: Reducing the Power of the Maladaptive Coping Modes – Long-Term Strategies

Make a list of things you can do, and your thoughts, when you notice that you're stuck in a version of the Maladaptive Coping Modes and it is not getting your need met. Today, list only things you can do over a longer period of time, to reduce your Maladaptive Coping Modes more permanently. Note that this will also help you modify your schemas.

	Reducing the Avoidant Protector	*Reducing the Compliant Surrenderer*	*Reducing the Overcompensator*
Example:	*My Avoidant Protector keeps me locked up in my apartment.*	*My Detached Protector stops me from telling people close to me what my boundaries are.*	*My Aggressive Protector stops me from having relationships with people who could really care about me.*

	Reducing the Avoidant Protector	*Reducing the Compliant Surrenderer*	*Reducing the Overcompensator*
Long-term behavioral pattern-breaking 	*I could go sit in the park for 20 minutes 3 times a week. If I manage to do so 2 weeks in a row I could start going to a café for 1 hr every week, and so on.*	*I could start by writing it down, when I realize that my Compliant Surrenderer takes over, because someone crossed my boundaries. Then I could try to discuss it with the person who crossed my boundaries that I feel most comfortable with. If that works out, I could try to do the same thing with people who feel more difficult to discuss it with.*	*I could try to intentionally start a new relationship, for example by joining a sports club. I could try to meet some of the people from the club after sports to find out whether I would like to be friends with them. I could pay special attention to the positive characteristics I notice in them.*
Related schema:	"Abandonment"	"Emotional Inhibition"	"Emotional Deprivation"
Your strategies			
Your related schema:			

	Reducing the Avoidant Protector	*Reducing the Compliant Surrenderer*	*Reducing the Overcompensator*
Example:	*My Avoidant Protector keeps me from having a job.*	*My Compliant Surrenderer tells me that I may as well not study for my midterm exam because I know that I will fail.*	*My Overcompensator stops me from recognizing my weaknesses or the strengths of others.*
Long-term cognitive strategies	*I could think about the competencies I have for a particular job. I could think about the pros and cons of working at that job and other jobs.*	*I could remember the group in which we talked about negative forecasting and realize that I am setting myself up to fail by not studying. I could remind myself that not trying is a sure way to fail. I could remind myself that I have passed exams and I am not a complete failure. I could start preparing for my midterm exams.*	*I could consider the fact that everyone has weaknesses, even me. When I deny mine I can get into trouble because I act like a know-it-all. I could think about the strengths of other people and not judge them so negatively. I could try to have a more balanced view of myself and others.*
Related schema:	"Unrelenting Standards"	"Failure/ Incompetence"	"Defectiveness/ Shame"

	Reducing the Avoidant Protector	*Reducing the Compliant Surrenderer*	*Reducing the Overcompensator*
Your strategies: 			
Your related schema:			

Example:	*My Avoidant Protector keeps me from doing any activity with other people.*	*My Compliant Surrenderer keeps me from having my own feelings and recognizing them.*	*My Overcompensator is really mean and hateful to my friends if they say something is going to happen and they don't follow through on it.*
Experiential techniques for long-term change	*I can recall in imagery how it felt to begin to feel safe in my therapy groups. In the imagery I can re-experience enjoying talking with the others in the breaks. I can access the warm*	*I can access the childhood memories this is connected to. Then I can ask my therapist to help me rescript those memories. I can then access the rescripted*	*If something like this happens, before I react to my friends I can give myself a couple of minutes to access the safety-bubble I learned in group. Then I can do a mode dialogue in*

	feeling in my belly that I had in these moments I can train myself to access this feeling three times a day, when I am in the company of other people (at work, in therapy …).	*situation by listening to it on my iPod. I can then try slowly access my feelings in the present and maybe even tell the people closest to me how I feel.*	*my mind to check in with the needs of my different modes. Then my Healthy Adult Mode can choose an appropriate action that won't damage my friendships.*
Related schema:	*"Isolation"*	*"Emotional Inhibition"*	*"Entitlement"*
Your strategies 			
Your related schema:			

We have worked out long-term behavioral, cognitive, and experiential strategies, techniques or skills that your Healthy Adult Mode can use to reduce the power of all the types of Maladaptive Coping Modes.

Below, make a Mode Management Plan for each Maladaptive Coping Mode that you experience and want to try out in the next few weeks – it can act as a flashcard for you to refer to while you are working on change.

Long-Term Mode Management Plan for my Maladaptive Coping Modes		
Avoidant Protector	*Compliant Surrenderer*	*Overcompensator*
Add more techniques to your plan as you try things and find out what works best for you.		

Don't expect your mode-change plan to be final today or even in a few weeks. There are always new techniques for long-term change to try out throughout your life. You can add new techniques as you discover them through treatment. We cannot tell you that your mode-change plan will work in every time or 100%, because no one's does. Some things are more difficult to change than others. What we can tell you is that they will work better in the long run than your Maladaptive Coping Modes. Mode Management Plans need to match specific kinds of situations and to be tested and fine-tuned. At the beginning you will probably need the help of your therapists, the treatment team, or your peers to add things to your plan – but over time your Healthy Adult will internalize all of these healthy coping techniques and you will get better at accessing them and remembering to stick to your plan.



In an intensive setting it is helpful to give a copy of this MMP to the treatment team so that all have access to it. In the inpatient setting it is helpful for the patients and staff members if another copy is kept easily available on the unit.

Session 2 focuses on the DyPMs. The same steps are gone through as for the previous modes. The only difference is that this time we ask patients what their HAM can say to their DyPM (Mode Management Session 2: Fighting Your Punitive and Demanding Parent Modes (MM 2-DyPM1)).

Mode Management Session 2: Fighting Your Punitive and Demanding Parent Modes

The Punitive and Demanding Parent Modes produce pressure and self-hatred and often trigger Maladaptive Coping Modes.

In Schema Therapy we want to strengthen your Healthy Adult Mode, practice ways he/she can stand up to your Punitive Parent Mode, and find ways in which he/she can reduce the demands of your Demanding Parent Mode to a reasonable level.

Imagine a situation in which you heard a message from your Dysfunctional Parent Modes.

What can your Healthy Adult Mode say to your Punitive Parent Mode?

_____

_____

_____

_____

_____

_____

What can your Healthy Adult mode say to your Demanding Parent Mode?

_____

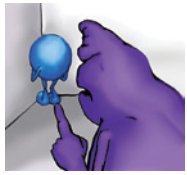
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One of the goals of Schema Therapy is to free you from the negative impact these Dysfunctional Parent Modes or internal critics have on you.

Fighting Your Punitive and Demanding Parent Modes: Short-Term Behavioral and Cognitive Strategies

Record what you can say or do, when you notice that you are stuck in your Punitive or Demanding Parent Mode and recognize that this is not good for you.

	Fighting your Punitive Parent Mode	*Fighting your Demanding Parent Mode*
Example:	*It's Monday morning and your "To do list" is full of tasks*:	
	Your Punitive Parent Mode: "You won't make it! You are such a loser. You will never amount to anything."	*Your Demanding Parent Mode: "You have to finish everything no matter what! I don't care how late you stay up – no breaks. There is no excuse not to finish everything perfectly.*
Short-term behavioral strategies	*I can say loud and clear "Stop. You are wrong. I have managed many stressful times in my life and I can do it again. I won't listen to you put me down like this!" Then I can start to work on one task at a time.*	*I can make a time table and do one task at a time. I will schedule in times for taking breaks, in which I will relax. I will also prioritize the list and do what is urgent today and what can be done tomorrow or even later.*
Your strategies:		
Example:	*You failed an exam*:	
	Your Punitive Parent Mode: "You are too stupid to succeed at anything. You are incapable and worthless."	*Your Demanding Parent Mode: "You should have studied much more! You shouldn't have done anything else even for a minute, now you must study every minute until you can take the makeup exam!"*

	Fighting your Punitive Parent Mode	*Fighting your Demanding Parent Mode*
Short-term cognitive strategies	*I can tell myself: "I failed an exam. That does not make me a failure. I didn't have enough time to prepare and I was distracted, because my grandma was dying. I was also unlucky with the questions in the exam. These are the circumstances that made it difficult for me. I am not incapable or stupid. I can also remember exam situations in which I have done really well, for example I completed college successfully. I won't listen to my Punitive Parent Mode. It is just wrong."*	*I can tell myself: "I need to study for the makeup exam, but I need to balance study and relaxation and get enough sleep to be in the best shape for the exam. I can remind myself this was the first exam of the semester so there is time to make up for it. The painful circumstances I had will not be there for the next exam."*
Your strategies:		

Fighting Your Punitive and Demanding Parent Modes: Short-Term Experiential Techniques

In the Experiential Mode Work group we tried techniques to fight the Punitive and Demanding Parent Modes on the experiential or emotion-focused level and we will try more over the course of your treatment. These techniques include the punishment-reinforcement exercise, effigy exercises, and others. Make a list of the techniques from that group that you can use when you want to stop or turn the volume down on your Dysfunctional Parent Modes.

Example:	*Your friend tells you she can't be there to support you all of the time.*	
	Your Punitive Parent Mode: "Nobody likes you. You are such a whiner. You are a burden to others. It would be better if you were dead."	*Your Demanding Parent Mode: "I told you, you needed to work harder on becoming healthy, if you did you wouldn't have to call her. You have to work harder, do you understand!"*
Short-term experiential techniques	*I can go back to the imagery exercise we did in which I found out that my Punitive Parent Mode has the voice of my first-grade teacher, who made me feel bad about everything I did. I can also remember the therapy session when we talked about how I don't want to treat myself the same way that teacher treated me. I can access the strength I felt in that moment and tell my Punitive Parent Mode to "shut up."*	*I can access the image of saying "stop" to the effigy of my Demanding Parent Mode. I can remember how it felt to have all the others in group telling my Demanding Parent Mode effigy that she was wrong and that she needed to shut up. I can access my HAM and find out what a reasonable number of times to call my friend would be – maybe three times a week and not every day.*
Your techniques: 		

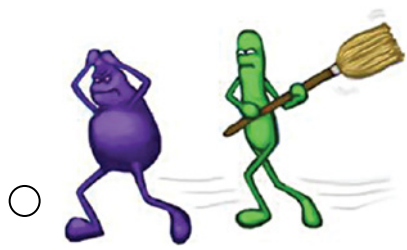
Short-Term Mode Management Plan to Fight My Punitive and Demanding Parent Modes

We have identified short-term behavioral, cognitive, and experiential strategies, techniques, and skills that your Healthy Adult Mode can use to fight the Punitive and Demanding Parent Mode.

Below, make a Mode Management Plan with your *preferred strategies and techniques* for each of the parent modes you experience. Keep this plan with you as a flashcard or an emergency plan while you are working on change.

Punitive Parent Mode	*Demanding Parent Mode*
Add more techniques to your plan as you try things and find out what works best for you.	

Don't expect your Mode Management Plan to be final today or even in a few weeks. You can add new techniques as you discover them through this program. We cannot tell you that your Mode Management Plan will work in every situation or 100%, because no one's does. What we can tell you is that it will work better in the long run than listening to your Dysfunctional Parent Modes. Mode Management Plans need to be designed to match specific kinds of situations and to be tested and fine-tuned. At the beginning you



will probably need the help of your therapists, the treatment team, and your peers to add things to your plan – but over time your Healthy Adult will internalize all of these healthy coping techniques and you will get better at accessing them and remembering to use them.

Session 3 focuses on the VCM. Again a short introduction to the VCM is given, distinguishing the sad and the anxious child versions. The experiential exercise of this session asks patients to imagine a VCM situation. Some patients are likely to choose a sad and others an anxious VCM situation. We ask patients to tell us what their Vulnerable Child needed to hear in the situation (Mode Management Session 3: Caring for Your Vulnerable Child Mode's Feelings of Sadness and Anxiety (MM 3-VCM1)). They record their answers on the exercise form. After that, we work on short-term or immediate behavioral and cognitive techniques to meet the needs of the VCM. We continue to distinguish between the sad and anxious VCMs as they require somewhat different antidotes. Again, an example is presented and the patients' personal situations and antidotes are collected. The same thing is done for experiential skills. On the last page, each patient records their mode management plan for the VCM.

Session 4 focuses on the ACM. For this mode it is important to be aware that skills need to fit two goals. A patient in the ACM needs to vent the anger in a non-damaging way, and to learn social competencies or interpersonal skills to be able to better fulfill their needs. The session follows the same procedure. We ask what the ACM needs to hear to feel attended to and heard (Mode Management Session 4: Managing Your Angry Child Mode (MM 4-ACM1)). We also validate their feeling in the form of "I can understand, given your childhood experiences, why this makes you furious (or you feel this intense about it)" or simply "Damn, that would be aggravating." It is important to point out that cognitive skills for the ACM are limited. When patients are in ACM their access to cognitive resources is restricted until their adrenaline level has reduced. In contrast, experiential skills can work extremely well for the ACM. Examples of experiential skills include: imagining bursting balloons, playing tug-of-war with the therapist.



Mode Management Session 3: Caring for Your Vulnerable Child Mode's Feelings of Sadness and Anxiety

When you experience the Vulnerable Child Mode (VCM) your predominant feeling is likely to be sad, anxious, or a combination of the two. When the VCM is sad, he/she may also feel lonely or hopeless and other feelings related to sadness. When the VCM is anxious, he/she may also feel fearful or scared and other feelings related to anxiety. It is also possible for the VCM to feel a combination of both sad and anxious feelings. One feeling that combines these two is "abandoned." In addition, sometimes when you are in the VCM you may just be aware of emotional pain and not have words for it. This is common when people are in a very young version of the VCM.

We look at the feelings involved to help figure out what the VCM's need is. Children who are sad or anxious need a good-parent adult to comfort and reassure them. Many people with psychological problems did not have adults in their childhood who could comfort and reassure them when they felt sad or anxious. So they never learned how to cope with those feelings. Often they have only learned that it is not OK to be sad or to be scared. Therefore they do not know what to do when in the VCM.

For sadness in your VCM, it is important to tell him/her that it is OK to be sad at times. This can be expressed by saying "It is OK to be sad. If that same thing had happened to me, I would be sad too. I can really understand that you feel sad and lonely right now." A good parent would console a sad child with words and actions: a hug, a shawl to wrap up in, rocking, hot cocoa, and so forth. These are all things that your Healthy Adult Mode (HAM) can learn to do. They may feel alien at first, but they will give the VCM what he/she needs.

For anxiety in your VCM, it is important to give him/her safety and protection. You can do that, for example, by saying "I am here for you. I will protect you. I will keep anything bad from happening to you." In some situations it will also be helpful to provide your VCM with guidance help the VC deal with the fear in an adaptive

way. For example, showing the VC that the thing it fears is not dangerous or eliminating the danger.

In both cases, when you have suppressed the VCM feelings for a long time, feeling them will also bring up some dependency. In ST it is a natural part of the healing process that your therapists act as good parents for your VCM. This provides your VCM the learning experience with a healthy role model that he/she did not have in childhood. Over time you will develop the Good Parent side of your HAM and be able to meet the needs of your VCM yourself. This process takes time and openness on your part to allowing the therapists' good parenting in and then developing your own Good Parent.

Imagine a situation in which you were in the VCM and felt sad.

What has your VCM heard from your therapists that felt comforting? What could the Good Parent part of your HAM say to your VCM to comfort him/her?

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Imagine a situation in which you were in the VCM and felt anxious or scared.

What has your VCM heard from your therapists that made you feel safe? What could the Good Parent part of your HAM say to your VCM to help him/her feel safe?

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_____
_____

It is our goal that your HAM is strengthened to become able to recognize the VCM's needs and be able to comfort and reassure his/her sadness or anxiety.

Caring for Your Vulnerable Child Mode: Short-Term Behavioral and Cognitive Strategies

Today we will be looking at short-term strategies to use when you are in the Vulnerable Child Mode and feeling sad or anxious.

Next time we work on this mode in the Mode Management group we will focus on long-term strategies.

	Comforting sadnessin the Vulnerable Child	*Reducing anxiety in the Vulnerable Child*
Example:	*I am in the VCM feeling sad because my friend has just told me that she will not come to visit me this evening.*	*I am in the VCM feeling anxious because I fear that I will not be able to find an outpatient therapist all by myself so I will be abandoned after discharge.*
Short-term behavioral strategies	*I could tell my roommate what happened. I could tell her that this makes me really sad and that I feel abandoned. Maybe my roommate will tell me that she also feels sad when somebody cancels a date. She might suggest that we have a nice evening in our room. If she doesn't make that suggestion, I could ask her if she would like to do something with me this evening, for example watch a movie or cook together.*	*I could ask the nursing staff to support me in making the phone calls to find an outpatient therapist. Together we could plan what I could say to leave an appropriate message on the therapist's voicemail. I could also ask one of my friends to take me to the therapist's office for the first few appointments.*
Your strategies: 		

	Comforting sadnessin the Vulnerable Child	*Reducing anxiety in the Vulnerable Child*
Example:	*I am in the VCM feeling sad, unloved, and lonely because nobody has called me all week long.*	*I am in the VCM feeling anxious because I fear that my roommate won't like me anymore, if I ask her to do her share of the cleaning.*
Short-term cognitive strategies	*I could think about calling someone, or if no one is available I could send an email. I could then recall some of the comforting things my therapist said to me and the plan we made for me to watch my favorite movie or listen to my favorite music when I was feeling like this.*	*I could consider what the odds are that my roommate will react in exactly that way. I could also consider what the worst thing that could happen to me would be if she did stop liking me.*
Your strategies:		

Caring for Your Vulnerable Child Mode: Short-Term Experiential Techniques

In the Experiential Mode Work group we tried some techniques to comfort and reassure the Vulnerable Child and we will try more of them over the course of your treatment. These techniques include connecting with others, imagery rescripting exercises, mode dialogues, and so forth. Make a list of experiential techniques to use when your Vulnerable Child Mode needs comfort or reassurance.

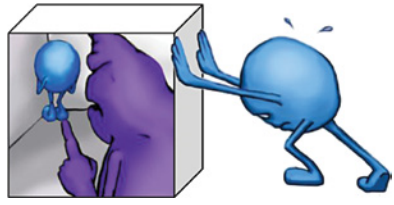
Example:	*My Vulnerable Child feels sad and unloved because the person I love doesn't want to be with me.*	*My Vulnerable Child is afraid of babysitting for my friend's little daughter.*
Short-term experiential techniques	*I can access the sad and lonely feelings I have in my belly and then recall what was said to my VCM yesterday in the imagery exercise in group. I can recall things like "I will be there for you."*	*I could do a mode dialogue with my HAM, reassuring my VCM by reminding her that "My friend says her daughter has always liked it when I visited. You made spaghetti for today. Kids like that. I know you can do a good job babysitting for your friend's daughter and you don't have to be perfect."*
Your techniques: 		

Short-Term Mode Management Plan for My Vulnerable Child Mode

We have worked out behavioral, cognitive, and experiential techniques or strategies that your Healthy Adult Mode can use to deal with sad and anxious feelings in your Vulnerable Child Mode.

Below, make a Mode Management Plan with your *preferred strategies and techniques* that you can keep with you as a flashcard or an emergency plan while you are working on change.

For comforting sadness	*For reducing anxiety*
Add more techniques to your plan as you try things and find out what works best for you.	



Don't expect your Mode Management Plan to be final today or even in a few weeks. You can add new techniques as you discover them through treatment. We cannot tell you that your Mode Management Plan will work in every situation or 100%, because no one's does. What we can tell you is that it will work better in the long run than your unhealthy Coping Modes or Parent Modes dealing with your Vulnerable Child Mode. Mode Management Plans need to match specific kinds of situations and to be tested and fine-tuned. At the beginning you will probably need the help of your therapists, the treatment team, and your peers to add things to your plan – but step-by-step your Healthy Adult will internalize all of these healthy coping techniques and you will get better at accessing them and remembering to use them.

Mode Management Session 4: Managing Your Angry Child Mode



Anger is the primary feeling of the Angry Child Mode. When you are in this mode, you may feel angry, enraged, frustrated, annoyed … but you can also just be very impulsive without being aware of any anger. If this is the case, we call it the Impulsive Child Mode rather than Angry Child Mode.

Some people with psychological problems have never had a healthy adult model who showed them how a child who is angry should be responded to and helped to express their anger safely. Often they just got the message that it is "not OK" to be angry. So, they never learned how to deal with their Angry Child Mode.

It is important that the Angry Child Mode is allowed to show anger and can say what makes him/her angry. Usually it is not just one thing but many, and even a large backlog. To make sure that all of this can be expressed it is necessary to allow enough time for venting. From your Healthy Adult Mode it is important to listen to the Angry Child Mode, hear the underlying need, take it seriously, and remember all of it.

In doing that, you can show the Angry Child that it is totally OK and normal to get angry, even at those who are close to you. You can convey this with validating statements like "I can really understand how angry you are about this." Or "Damn! I would be angry about that too." After venting and validation it is important to look at what the needs of the Angry Child are and what the options are for getting them filled. It is also important to look at how he/she can deal with anger in the future to be able to express it effectively and safely – without damaging self, others, or their relationships. Some people have suppressed their Angry Child Mode for such a long time that it takes time to even discover their feelings of anger. Others are afraid of their anger and think that they have no control when in Angry Child Mode. That is why it is important in the beginning of doing this work to have a model from the therapist of how a good parent would respond to and

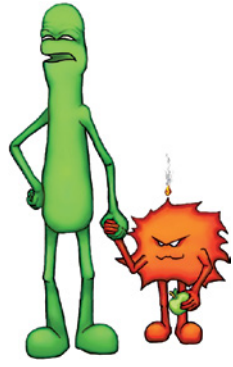
help the Angry Child. Over time you can internalize this healthy way of dealing with the Angry Child part of you into your Healthy Adult Mode.

Imagine a situation in which you are in your Angry Child Mode.

What does your Angry Child Mode need to hear so that he/she feels heard and attended to? How can you say this from your Healthy Adult Mode?

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A goal of Schema Therapy is that your Healthy Adult Mode be able to help your Angry Child Mode vent his/her anger in a non-damaging way and over time channel that anger into healthy assertive skills that the Healthy Adult Mode can use to clarify your personal boundaries, express your needs, and reach your goals.



Managing Your Angry Child Mode: Short-Term Behavioral and Cognitive Strategies

Make a list of the self-talk and actions you can use when you feel stuck in the Angry Child Mode and are not getting your need met. For now, we will look at things that can help you immediately. Next time we work on this mode we will focus on things you can do long term to reduce the intensity of this mode. One warning: when the Angry Child Mode is very intense, cognitive skills are not very effective. At those times we are flooded with adrenaline and clear thinking is difficult! Don't forget that part of managing the ACM is identifying the unmet need that is triggering your anger. Often you must do that later when you are less angry.

	Managing Your Angry Child Mode
Example:	*I am in the Angry Child Mode because my friend cancelled our date, because she prefers doing something with her boyfriend. I want to yell at my friend and tell her never to contact me again!*
Short-term behavioral strategies	*I could take my boxing gloves and hit the boxing bag until I have physically vented my anger and feel less tense. Then I could send an email to my friend in which I tell her that it makes me really angry when she cancels dates on short notice, because she prefers to see her boyfriend. I feel like I always come last and am not important to her. I want her to plan better in the future so that she can see her boyfriend and have time for our friendship. I could write that in the email also.*
Your strategies: 	
Example:	*I am in the Angry Child Mode because my mother told her friends that I failed my driver's license exam.*
Short-term cognitive strategies	*After venting my anger, I analyze what boundaries my mother has stepped over by her behavior and what action I want to take. I can plan what I need to say to her about this and what skills I might need to do that in an assertive and not aggressive way.*
Your strategies:	

Managing Your Angry Child Mode: Short-Term Experiential Techniques

In the Experiential Mode Work group we tried some experiential techniques to manage your Angry Child Mode and we will try others over the course of the program. These techniques include connecting to others, imagery rescripting, mode dialogues, and mode role-play exercises, among others. Make a list of the experiential techniques you can use to reduce the intensity of your Angry Child Mode and avoid taking reckless action.

Example:	*My Angry Child Mode wants to hit my boss for invalidating me in front of others.*
Short-term experiential techniques	*I can feel my muscles getting really tense. I can imagine a balloon in which I put all my anger and let it go. Today I have to imagine a couple of balloons flying in the air until I feel relieved. Then I can remember being in group and the therapist asked me what I needed – and then respected what I asked for. Maybe I need to say that I want to be treated with respect in this situation, too.*
Your techniques: 	

Short-Term Mode Management Plan for
My Angry Child Mode

We have worked on behavioral, cognitive, and experiential techniques or skills that your Healthy Adult Mode can use to manage the Angry Child Mode. Below, make a Mode Management Plan with your *preferred strategies and techniques*. Keep this plan with you like a flash-card or an emergency plan while you are working on change.

Angry Child Mode
Add more techniques to your plan as you try things and find out what works best for you.




Don't expect your Mode Management Plan to be final today or even in a few weeks. You can add new techniques as you discover them through this program. We cannot tell you that your Mode Management Plan will work in every situation or 100%, because no one's does. What we can tell you is that it will work better in the long run than your Maladaptive Coping Modes or Dysfunctional Parent Modes are in dealing with your Angry Child and your underlying needs. Mode Management Plans need to be designed to match specific kinds of situations and to be tested and fine-tuned. At the beginning you will probably need the help of your therapists, the treatment team, and your peers to add things to your plan – but over time your Healthy Adult will internalize all of these healthy coping techniques and you will get better at accessing them and remembering to use them.

Session 5 focuses on the HCM and the goal is to develop a short-term plan either to access that mode or to stay in it. This session follows the same procedure, adding a short discussion about what their HCM enjoys (Mode Management Session 5: Developing Your Happy Child Mode (MM 5-HCM1)). If there is interference with enjoyment, we determine how their HAM can intervene. In doing this, refer to the Mode Awareness group where modes that interfere with the HCM were identified. In the Mode Management Plan for the HCM it is important to identify positive activities that might trigger a patient's HCM.

Mode Management Session 5: Developing Your Happy Child Mode



When you are in Happy Child Mode, you feel loved, content, connected to others, met in your core emotional needs, fulfilled, protected, praised, worthy, provided for, led, understood, appreciated, safe, optimistic, and spontaneous.

Most people with a psychiatric disorder did not have an environment in their childhood that encouraged and supported them in being happy or playful. That is why they often don't know what they enjoy doing and they have not developed hobbies or leisure activities for their lives.



It is important that the Happy Child Mode can express his/her happiness and do things that make him/her happy. It is important to give your Happy Child Mode the possibility to express creative impulses or expressions. As a Healthy Adult it is useful to be open to a wide range of possibilities for joy and pleasure for the Happy Child. It is also important to be able to connect with the Happy Child in you and pay attention to information from him/her about what is wanted.



Some people have suppressed their Happy Child Mode for such a long time that it takes work in therapy to access feelings of joy and happiness. For this reason, schema therapists call your Happy Child out to play and explore, and help you learn more about the Happy Child Mode and

develop a sense of play and fun. Later on, your Healthy Adult Mode can learn to do this for you.

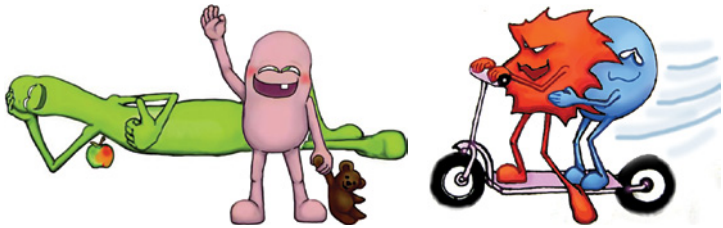
What does your Happy Child Mode enjoy?

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What does your Happy Child need to hear from your Healthy Adult Mode so that he/she is able to come out to play and enjoy life?

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It is a goal of Schema Therapy to encourage your Healthy Adult Mode to help your Happy Child Mode develop a sense of play and fun and to plan time for hobbies and leisure.



Strengthening the Happy Child Mode: Short-Term Behavioral and Cognitive Strategies

Make a list of things you can think and do to develop your Happy Child Mode. Today we will look at short-term strategies that can help you get into your Happy Child Mode. Next time we work on this mode we will focus on things you can do in the long term to work on developing this mode. Because in this mode you feel good!

	Developing Your Happy Child Mode
Example:	*I am in Happy Child Mode when I spend time with friends and play beach volleyball.*

	Developing Your Happy Child Mode
Short-term behavioral strategies	*I could spontaneously call my friend after work and ask her if she has time to go to my favorite coffee place and chat. If she doesn't have time I could walk over to the beach volleyball field and see if anyone's around. Maybe I can find a game to join.*
Your strategies:	
Example:	*I am in Happy Child Mode when I can remember happy moments.*
Short-term cognitive strategies	*I could think about the things we did in summer and how I felt about the activities.*
Your strategies: 	

Strengthening Your Happy Child Mode:
Short-Term Experiential Techniques

In the Experiential Schema Therapy group we tried some techniques to strengthen the Happy Child Mode on the emotional or experience-based level and we will try more of them through the course of your treatment. These techniques included connecting to others, games and play, and other fun things. Make a list of experiential techniques to use when you want to access your Happy Child Mode and call him/her out to play.

Example:	*I am in Happy Child Mode when I eat cookies & cream flavored ice cream.*
Short-term experiential techniques	*I can do an imagery exercise like we did in group. I can imagine walking into an ice cream store and ordering a gigantic ice cream in a chocolate-dipped waffle cone.*

	I can order cookies & cream flavored ice cream – I can order three big scoops. Then I can put M & Ms on top of my ice cream and some chocolate sauce. I can smell the ice cream and feel the cold when I hold the cone in my hand. I can dip a spoon into my ice cream and put a spoonful in my mouth – I can taste the cookie & cream flavor, the rich chocolate, the crunch of the M&Ms … yummy.
Your strategies: 	

Short-Term Mode Management Plan for My Happy Child Mode

We have worked on behavioral, cognitive, and experiential techniques or skills that your Healthy Adult Mode can use to access and encourage your Happy Child Mode to come out and play.

Below, make a Mode Management Plan with your *preferred techniques* to carry with you as a flashcard reminder while you are working on change.

Happy Child Mode
Add more techniques to your plan as you try things and find out what works best for you.



Don't expect your Mode Management Plan to be final today or even in a few weeks. You can add new techniques as you discover them through treatment. We cannot tell you that your Mode Management Plan will work in every situation or 100%, because no one's does. What we can tell you is that it will work better and make you happier in the long run than your Maladaptive Coping Modes or Dysfunctional Parent Modes in dealing with your Happy Child Mode. Mode Management Plans need to match specific kinds of situations and to be tested and fine-tuned. At the beginning you will probably need the help of your therapists, the treatment team, and your peers to add things to your plan – but over time your Healthy Adult will internalize all of these healthy coping techniques and eventually they will become automatic.

Session 6 focuses on the HAM and the same format is followed. This time we are looking at the triggering of healthy behaviors (Mode Management Session 6: Strengthening Your Healthy Adult Mode (MM 6-HAM1). There is no MMP needed for the HAM.

Mode Management Session 6: Strengthening Your Healthy Adult Mode

When you are in this mode, you support and validate your Vulnerable Child Mode, you set limits for your Angry and Impulsive Child Mode, you support and develop your Happy Child Mode, and you fight your Maladaptive Coping Modes and Dysfunctional Parent Modes, replacing them with healthy coping strategies and reasonable standards.

In the Healthy Adult Mode we are able to balance needs and responsibilities so that we can enjoy life but also have fulfilling work. From the Healthy Adult Mode we take on adult functions like work, parenting, and other duties and pursue pleasurable activities like sexuality, intellectual and cultural interests, our health, and sports.



One part of our Healthy Adult Mode is the Good Parent. The "Good Parent" is the healthy part of what we have taken in or internalized from important people in our life, including our psychotherapists and fellow group members.

A childhood environment where love, support, encouragement, validation, and consistency are provided and experienced promotes the development of a strong Healthy Adult Mode. Most people with a psychiatric disorder did not have such a childhood environment, but the good news is that this can be corrected in the environment of Schema Therapy.

In Individual and Group Schema Therapy you can have corrective emotional learning experiences with the support and validation of therapists and peers. These will allow you to connect with and develop your Healthy Adult Mode. Whatever your chronological age, it is not too late to do this and reap the benefits.

What can your Healthy Adult Mode say to:

1. Your Maladaptive Coping Modes



2. Your Vulnerable Child Mode

3. Your Angry/Impulsive Child Mode

4. Your Punitive Parent Mode

5. Your Demanding Parent Mode

6. Your Happy Child Mode

Developing and strengthening your Healthy Adult Mode is an important goal of Schema Therapy.

Strengthening Your Healthy Adult Mode: Short-Term Behavioral and Cognitive Strategies

List things you can think or do to strengthen your Healthy Adult Mode.

In this mode your thinking is clear and you can access your healthy coping strategies without interference from old Maladaptive Coping Modes or Dysfunctional Parent Modes.

	Strengthening the Healthy Adult Mode
Example:	*I am in my Healthy Adult Mode when I manage to set a limit without feeling guilty about it.*
Short-term behavioral pattern-strengthening strategies	*I could say "No, I can't help you right now, but I will try to get back to you later when I feel better" when I am aware that I have no resources left to help my girlfriend, because I have a lot to deal with myself. I could allow myself to do something that is good for me to replenish my resources.*
My strategies:	

	Strengthening the Healthy Adult Mode
Example:	*I am in my Healthy Adult Mode when I can keep calm in a stressful situation and do not lose trust in myself.*
Short-term cognitive strategies	*I could think about how many situations I have managed well so far and give myself positive instructions like "You will do really well, it is just a challenge, you can meet it!"*
My strategies:	

Strengthening Your Healthy Adult Mode:
Short-Term Experiential Techniques

In the Experiential Schema Therapy group we tried some techniques to strengthen your Healthy Adult Mode on the emotional or experience-based level and we will try more of them over the course of your treatment. Since the Healthy Adult Mode is there to manage all the other modes, these techniques include all of the ones you heard about in your previous Schema Therapy groups and individual sessions. Make a list here of the experiential techniques you can use when you are in the Healthy Adult Mode.

Example:	*I am in my Healthy Adult Mode when I take care of my kids.*
Short-term experiential techniques	*When I am taking care of my kids by reading a night-time story to them, I can try to collect this as a memory by paying close attention to the experience, what it feels like, how they look, and so on. I can recall this experience in imagery a few times before I go to sleep and allow myself to take it in as evidence of my caring as a mother or father.*
Your techniques:	

You now know how to monitor your modes. You can use your Mode Awareness handouts to keep track of them. We have worked out behavioral, cognitive, and experiential strategies, techniques, and skills that your Healthy Adult Mode can use to manage all other modes. You have a Mode Management Plan for each mode. Make these easily accessible, for example as flashcards, so that you can refer to them whenever you need to. And never forget that you have a Healthy Adult Mode to call upon!



Sessions 7–11 focus on long-term MMPs for the rest of the modes. These plans involve more steps over a period of time and can lead to change in the underlying early maladaptive schemas that trigger modes. When modes change, schemas may also be affected, so one part of the long-term handout asks which schema might be affected by changing a mode in specific situations. The modes in this group of sessions follow the usual sequence and employ the same session structure. We go over examples of long-term strategies in the session for each mode. A long-term MMP is developed for each mode and recorded on the session handout. These plans focus on changes that patients want to start in the following weeks. The continued use of MMPs formulated in the treatment program outside of sessions is one of the strategies to support generalization post-treatment.

Mode Management Session 8: Long-Term Strategies to Fight Your Dysfunctional Parent Modes

List strategies to use over a longer period of time to fight your Punitive Parent and Demanding Parent Modes more completely or permanently. Reducing the power of these Dysfunctional Parent Modes will also help you modify your schemas.

	Fighting your Punitive Parent Mode	*Fighting your Demanding Parent Mode*
Example: 	*You feel stressed because you have an important interview tomorrow*: *Your Punitive Parent Mode says: "You will never succeed. You failed last time and will again. You are a loser!"*	*Your colleagues sit together at a table during lunch and talk about an author you have never heard of. Your Demanding Parent Mode says: "You need to take a part in the conversation right now or nobody will like you. You must read more, so you will also know the authors that people talk about. You have to say something clever or you will embarrass yourself completely."*
Long-term behavioral pattern-breaking strategies	*I say loudly: "No!" and I will say it again and again, if my Punitive Parent Mode starts up again. I can practice the job interview with my therapist in a role-play. I could practice any difficult situations in role-plays, so that I will know I can manage them confidently.*	*I ignore my Demanding Parent Mode and say: "I don't know that author, what did he write?" or "Could one of you lend me a book by him? It really sounds interesting." I could participate in conversations, even if I don't have all of the perfect answers to all questions.*
Related schema:	"*Failure*"	"*Unrelenting Standards*"
Your strategies:		
Your related schema:		

Example:	*Since the beginning of the week you have been thinking about cancelling your date for Friday. Your Punitive Parent Mode says: "Nobody likes you. Look at you, you are so boring and ugly."*	*You have the feeling lately that you are not enough for anyone and that you are not interesting to others, unless you are giving to them in some way. Your Demanding Parent Mode says: "You must always be helpful and supportive and take responsibility for meeting other people's needs."*
Long-term cognitive strategies	*I could tell myself: "That is not true! The time of my terrible acne and dental braces was over ages ago." I could remind myself of various compliments I have been given on my style, my eyes. I could wear the dress I feel prettiest in and make sure that I have a good night's sleep to look rested. I could remind myself that only my Punitive Parent voice calls me names like that and it is wrong.*	*I could remind myself that I try to do my best for my friends. And what I do is enough. It is important for me to take time for myself also. I could decide who my two best friends are and focus on spending time with them, then take time for myself and only after that look after other friends' needs.*
Related schema:	"*Defectiveness*"	"*Self-Sacrifice*"
Your strategies: 		
Your related schema:		

Example:	*You feel bad because you made a mistake.* *Your Punitive Parent Mode says: "You are an idiot. You need to be punished – no dinner for you today!"*	*You feel under pressure because your best friend asked you to make her wedding bouquet.* *Your Demanding Parent Mode says: "You had better make at least three of them to make sure one is good enough. It may take all night, but it has to be perfect. It must be perfect."*
Experiential techniques for long-term change	*I can rescript my past experiences by remembering the Good Parent Script my therapist read in group and imagine my Healthy Adult Mode and tell myself: "It is OK to make mistakes. There is no way around them. Now, let's go and try to correct the mistake and then let's have dinner. Punishing yourself does not help you learn from your mistakes, it just makes you feel bad."* *I can make myself a little box with notes from my Good Parent that contradict my Punitive Parent Mode and look at one every morning.*	*I will do an imagery exercise of the times when my friend told me that my bouquets were the most beautiful she had ever seen and how happy she looked when she asked me to make her wedding bouquet because I was such a gifted florist. I felt relieved and connected with my confidence and trust in my abilities – the pressure was taken off me. Because it is still hard for me to resist my Demanding Parent Mode, a first step could be to access this feeling of relief and confidence every day and start asking myself if this is a way I want to feel like more often.*
Related schema:	"*Failure*"	"*Unrelenting Standards*"

Your strategies: 		
Your related schema:		

We have worked on behavioral, cognitive, and experiential strategies, techniques, and skills that your Healthy Adult Mode can use to fight your Punitive and Demanding Parent Modes.

Below, make a Mode Management Plan with your *preferred strategies and techniques* for each version that you experience. Keep it with you as a flashcard to remind you of your long-term plan while you are working on change.

Long-Term Mode Management Plan for my Dysfunctional Parent Modes	
Demanding Parent Mode	*Demanding Parent Mode*
Add more techniques to your plan as you try things and find out what works best for you.	



Don't expect your Mode Management Plan to be final today or even in a few weeks. You can add new techniques as you discover them through treatment. We cannot tell you that your Mode Management Plan will work in every situation or 100%, because no one's does. What we can tell you is that it will work better in the long run than listening to your Dysfunctional Parent Modes. Mode Management Plans need to match specific kinds of situations and to be tested and fine-tuned. At the beginning you will probably need the help of your therapists, the treatment team, and your peers to add things to your plan – but over time your Healthy Adult Mode will internalize all of these healthy coping techniques and you will get better at accessing them and remembering to use them.

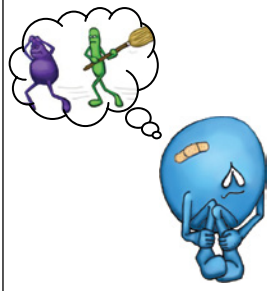
Mode Management Session 9: Long-Term Strategies to Meet the Needs of Your Vulnerable Child Mode

Make a list of long-term strategies to work on to meet the needs of your Vulnerable Child Mode (VCM). Choose strategies that over time can lead to more permanent change. As modes change, the schemas that trigger them do as well, so there is less triggering of modes.

	Comforting the Vulnerable Child Mode's sadness	*Reassuring the Vulnerable Child Mode's anxiety*
Example:	*I am often in the VCM feeling sad and abandoned when I feel isolated or distant from other people.*	*When I am in the VCM feeling anxious I think that I can't ask questions when I don't understand something.*

	Comforting the Vulnerable Child Mode's sadness	*Reassuring the Vulnerable Child Mode's anxiety*
Long-Term behavioral pattern-breaking strategies 	*I could participate in a social activity that I enjoy and where I will meet other people (for example: sing in a choir, play football in a club, volunteer at a homeless shelter). Over time I will have more connections with people.*	*I could start by asking a close friend, who I know is OK with questions, to explain it again. Next, I could ask someone, who I know has less time, to explain it again. Finally I could try asking someone, who I think is difficult to talk to (e.g., people at the job center, my boss). I know in my Healthy Adult (HAM) that nothing terrible will happen taking those steps and it will build my confidence in the HAM.*
Related schema:	*My related schema could be "social isolation."*	*My related schema could be "defectiveness/shame."*
Your strategies:		
Your related schema:		

	Comforting the Vulnerable Child Mode's sadness	*Reassuring the Vulnerable Child Mode's anxiety*
Example:	*In the Vulnerable Child Mode when I am sad I believe that I am helpless.*	*In the Vulnerable Child Mode when I feel anxious I believe that I cannot manage daily life by myself.*
Long-term cognitive strategies	*I could make a Pro/Con list looking at evidence that supports the belief that I am helpless and evidence that argues against it. I can remind myself that everyone needs help sometimes. I can identify the situations I feel helpless in and what help I need or why I need help. For important or recurring situations I can learn the skills I need.*	*I could make a list of all the daily chores that I have been able to do at least once. I can catch myself when I start thinking that I can't do anything. I can make a list with all the chores that have to be done and then if I need help with particular chores I can determine who could assist me or what I need to learn.*
Related schema:	*My related schema could be "dependence."*	*My related schema could be "failure/incompetence."*
Your strategies:		
Your related schema:		

Example:	*When I am in my Vulnerable Child Mode I often feel lonely.*	*When I am in my Vulnerable Child Mode I am afraid of talking to people.*
Experiential techniques for long-term change 	*In imagery I can re-experience how it feels to be connected to others in therapy groups. In my imagery I can again feel the warmth in my belly I had in those moments. I can do imagery work every evening before going to sleep and really go into the experience of feeling connected to others. This will train me to be able to access these comforting memories when feelings of loneliness or abandonment are strong.*	*I know that this probably has to do with my Punitive Parent Mode telling my VCM when I feel anxious that I am unwanted. I can remember a mode dialogue from group when another patient told me that she really wanted to talk to me because she thought I was nice. I can remember that as a Good Parent message, write it down on a flashcard and put it in front of me at work, where I have to talk to people. This will remind me that there are people who want to talk to me.*
Related schema:	*My related schema could be "abandonment."*	*My related schema could be "defectiveness/shame."*
Your strategies:		
Your related schema:		

We have identified long-term behavioral, cognitive, and experiential strategies, techniques, and skills that your Healthy Adult Mode can use to meet the needs of the Vulnerable Child Mode and help him/her heal.



Record your Mode Management Plan of long-term strategies to use for feelings of sadness or anxiety in the VCM. Try the plan out over the next few weeks to evaluate it. Use the plan as a reminder and to refer to while you are working on change.

Long-term Mode Management Plan for My Vulnerable Child Mode	
For Sadness	*For Anxiety*
Add more techniques to your plan as you try things and find out what works best for you.	

Don't expect your mode-change plan to be final today or even in a few weeks. There are always new techniques to try and add to

the plan throughout your life. We can't tell you that your mode change plan will work 100%, because no one's does. Some things are more difficult to change than others. What we can tell you is that it will work better in the long run than your Maladaptive Coping Modes or Dysfunctional Parent Modes do in meeting the needs of your VCM. Mode-change plans need to be matched to situations and to be tested and fine-tuned. Over time your Healthy Adult will get better at accessing them and your Mode Management Plan will become automatic.

Mode Management Session 10: Long-Term Strategies to Manage Your Angry Child Mode

Make a list of the healthy self-talk and actions you can use when you notice that you're in the Angry Child Mode. For now, list things that you can do over a longer period of time, to help change the mode more permanently. Long-term change will also modify your schemas.

	Managing Your Angry Child Mode
Example:	*I am often in Angry Child Mode when appointments are cancelled.*
Long-term behavioral pattern-breaking strategies	*I could go to the gym on a regular basis and work on being less physically tense. I could also work on my interpersonal skills by communicating my boundaries to other people more often ("I do not want that …," "In the future I would like …").*
Related schema:	"*Abandonment*"

	Managing Your Angry Child Mode
Your strategies: 	
Your related schema:	



Example:	*My Angry Child Mode feels enraged if nobody pays any attention to her.*
Experiential techniques for long-term change	*I can remember the exercise from group when we played tug-of-war. I can attach a towel to my door and pull as hard as I can, because I know now that is a safe way for me to release anger. When I feel that the explosive part of my anger is vented (and I know how that feels by accessing how it felt in group), I can tell the people close to me that it is important to me that they pay attention to my needs.* *I can monitor my Angry Child Mode's need for attention for a couple of weeks. I can access how it feels when my Angry Child's need is getting met. I can recall this once a day when I find from my monitoring that I am in the Angry Child Mode. This would make it easier for me to talk about what I need instead of exploding and more likely that others will listen.*

Related schema:	"*Emotional Deprivation*"
Your strategies: 	
Your related schema:	

We have worked on behavioral, cognitive, and experiential strategies, techniques, and skills that your Healthy Adult Mode can use to manage your Angry Child Mode.

Below, make a Mode Management Plan with your *preferred strategies and techniques* to keep with you as a flashcard to remind you of your long-term plan for change.

Long-Term Mode Management Plan for My Angry Child Mode
Add more techniques to your plan as you try things and find out what works best for you.



Don't expect your Mode Management Plan to be final today or even in a few weeks. You can keep adding new techniques as you discover them. We can't tell you that your Mode Management Plan will work in every situation or 100%, because no one's does. What we can tell you is that it will work better in the long run than your Maladaptive Coping Modes or Dysfunctional Parent Modes do in dealing with your Angry Child Mode. Mode Management Plans need to match specific kinds of situations and to be tested and fine-tuned. At the beginning you will probably need the help of your therapists, the treatment team, and your peers to add things to your plan and even be reminded to use it – but step-by-step your Healthy Adult will internalize all of these healthy coping techniques and you will get better at accessing them and remembering to use them.

Mode Management Session 11: Long-Term Strategies to Strengthen Your Happy Child Mode



Make a list of things you can think and do to develop your Happy Child Mode. Today we will look at strategies you can use over a longer period of time, to strengthen your Happy Child Mode permanently. Note that this will also help you modify your schemas.

	Developing Your Happy Child Mode
Example:	*I am in the Happy Child Mode when I spend time with friends and play beach volleyball.*
Long-term behavioral pattern-strengthening strategies	*I could try to find a beach volleyball team that I can join. Then I will be able to play many times during the week or weekend.*

	Developing Your Happy Child Mode
Related schema:	*My related schema could be "social isolation."*
Your strategies:	
Your related schema:	
Example:	*I am in Happy Child Mode when I can remember happy moments.*
Long-term cognitive pattern-strengthening strategies	*I could make myself a "Happy moments" wall, decorated with pictures or mementoes of happy moments. I could stand in front of it every day before going to sleep and think about what exactly made me so happy that moment.*
Related schema:	"*Negativity*"
Your strategies:	
Your related schema:	

Example:	*I am in the Happy Child Mode when I eat cookies & cream ice cream.*
Experiential techniques for long-term strengthening	*I can eat cookies & cream ice cream in various situations, with friends or while watching a fun movie. I can then re-experience the situations in imagery for my Happy Child Mode. I can evoke and strengthen my Happy Child Mode whenever I want to by using the imagery of what it feels like to enjoy eating ice cream.*

Related schema:	"*Emotional Deprivation*"
Your strategies:	
Your related schema:	





We have worked out behavioral, cognitive, and experiential strategies, techniques, and skills that your Healthy Adult Mode can use to strengthen your Happy Child Mode.

Below, make a Mode Management Plan for your Happy Child Mode that you want to try out in the next few weeks – it can act as a flashcard to refer to while you are working on change.

Long-Term Mode Management Plan for My Happy Child Mode
Add more techniques to your plan as you try things and find out what works best for you.

Don't expect your Mode Management Plan to be final today or even in a few weeks. You can add new techniques as you discover them through treatment. We cannot tell you that your Mode Management Plan will work in every situation or 100%, because no one's does. What we can tell you is that it will work better and make you happier in the long run than your Maladaptive Coping Modes or Dysfunctional Parent Modes in dealing with your Happy Child Mode. Mode Management Plans need to match specific kinds of situations and to be tested and fine-tuned. At the beginning you will probably need the help of your therapists, the treatment team, and your peers to add things to your plan – but over time your Healthy Adult will internalize all of these healthy coping techniques and eventually they will become automatic.



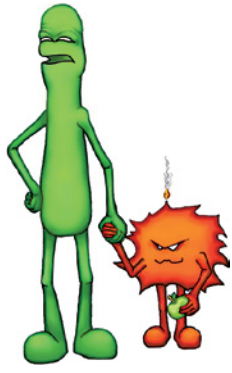
Mode Management Session 12: Long-Term Strategies to Strengthen Your Healthy Adult Mode

Make a list of long-term strategies to strengthen your Healthy Adult Mode. Choose strategies that over time can lead to more permanent change. As modes change, the schemas that trigger them do as well, so there is less triggering of modes.

	Strengthening Your Healthy Adult Mode
Example:	*I am in my Healthy Adult Mode when I set appropriate boundaries.*
Long-term behavioral pattern-strengthening strategies	*I could make a list of the things that make me upset, like my co-worker leaving her coffee cup on my desk, my roommate not cleaning the bathroom, and my mom calling me every night. I could then rate on a scale from 1 to 5 how upset these things make me (coffee cup=3, bathroom=4, mom's calls=5). Then I could start with the easiest task and write down what I could say to my co-worker, then rehearse it in front of the mirror for a few days, then say it to her. I can evaluate how it went. After that I can take on the next situation in order of difficulty.*
Related schema:	"*Subjugation*"
Your strategies:	
Your related schema:	
Example:	*I am in the Healthy Adult Mode when I believe in myself.*
Long-term cognitive strategies	*I could collect information about my successes and failures and write down both in a Pro/Con list in my iPhone. I must be specific beforehand about which area I am looking at (for example, responding to customer phone calls at work). Then I can evaluate at the end of the month whether or not I have good reasons to believe in myself.*
Related schema:	"*Failure*"

	Strengthening Your Healthy Adult Mode
Your strategies:	
Your related schema:	

Example:	*I am in Healthy Adult Mode when I am able to balance my own needs and those of others.*
Experiential techniques for long-term change	*When a conflict arises, I can start by recalling in imagery how I feel when I meet my own needs versus when I meet only the need of the other person. I can go back to the situations that we had in the group when needs conflicted and how no one was sacrificed – we found a way to compromise. I can feel again what it was like to feel like I mattered too. I can think about ways to compromise here and discuss those with the other person.*
Related schema	"*Self-Sacrifice*"
Your strategies:	
Your related schema:	



Therapist Notes: Mode Management Groups 7–12

What follows is a sample script of how we present the Mode Management work to patients. This sample session is for the Vulnerable Child Mode. In sessions 7–12 you will be presenting material in a similar way for each of the other main modes. You can use the same sample script and substitute the mode your session is on. We have also provided some therapist tips for dealing with issues that frequently arise in these sessions.

> *Hello, I am glad that you are all here and I am happy to see you. This is the Mode Management group and in the sessions of this group we will focus on specific skills you can use if you notice that you are often stuck in a mode that doesn't meet your need. But before we start, we would like you to feel your feet on the floor, take a few deep breaths, and pull your attention to being here in the group with us all.*
>
> *Here is a handout that we will work with today. We focus on one mode at a time. The mode we are focusing on will be the main emphasis in your other groups and your individual session. Each session of Mode Management focuses on a different mode – today it is the Vulnerable Child Mode* (fill in the mode of focus here). *Now, remember that in the Vulnerable Child Mode (VCM) you can have different feelings such as sadness, loneliness, anxiety, or fear.*
>
> *Today we will work on long-term strategies to meet the needs of your VCM. OK, let's look at today's handout.*

Give them the Mode Management handout for the session. Collect what patients say. Reinforce statements by nodding or praising patients.

Here you go over the example in detail, answering patients' questions and facilitating group members' involvement in the discussion. What follows is an example of how we present the examples.

> *Today we want to look at strategies that over time can lead to more permanent change. As modes change, the schemas that trigger them do as well, so there is less triggering of modes. Today we will focus on things you can do in the long term to meet the needs of VCM more permanently.*
>
> *Let's go through the example for comforting the Vulnerable Child Mode's sadness*:
>
> "*I am often in the VCM feeling sad and abandoned when I feel isolated or distant from other people.*"
>
> ○ *How many of you know this feeling? Have felt that way at any time?*

Acknowledge everyone who indicates knowing feelings like this when in the VCM. Head nodding should also be acknowledged in order to shape their participation. It can take patients some time to talk in group, so it is important to encourage their participation by reinforcing small steps, including nonverbal involvement.

> *Alright, let's look at long-term behavior pattern-breaking strategies to work on that mode*:
>
> "*I could participate in a social activity that I enjoy and where I will meet other people (for example: sing in a choir, play football in a club, volunteer at a homeless shelter). Over time I will have more connections with people. The related schema could be social isolation.*"
>
> ○ *OK, so one way to comfort the VCM's sadness and to work on one's social isolation schema is to engage in a social activity. Has anyone tried that? OK, and how did it work? That is really good. OK, what about other things could you do in the long term to work on reducing the sadness of your VCM? Which schema would you be working on then?*

If your patients cannot think of other behavioral pattern-breaking strategies, make suggestions yourself, like progressively difficult steps in contacting people: for example, by email, phone, personal contact, using transitional objects.

Yes, those are great ideas. Let's write them all down, so you have additional strategies to choose from the next time you are in a VCM.

OK, now let's look at the next example.

"In the Vulnerable Child Mode when I am sad I believe that I am helpless."

Which long-term cognitive strategies could help to work on this mode?

"*I could make a Pro/Con list looking at evidence that supports the belief that I am helpless and evidence that argues against it. I can remind myself that everyone needs help sometimes.*

I can identify the situations I feel helpless in and what help I need or why I need help. For important or recurring situations I can learn the skills I need. The related schema could be dependence."

What other long-term cognitive strategies can you use to work on VCM's sadness? Which schema would you be working on?

If your patients cannot think of other cognitive strategies, come up with suggestions yourself, like differentiating situations, clarifying the need, and so forth.

Yes, those are great ideas. Let's write them all down, so you can pick from different skills the next time you are in a VCM.

OK, now let's look at the next page.

"*When I am in my Vulnerable Child Mode I often feel lonely.*"

Which experiential techniques for long-term change could help to work on this mode? Let's look at the example.

"*In imagery I can re-experience how it feels to be connected to others in therapy groups. In my imagery I can again feel the warmth in my belly I had in those moments.*

I can do imagery work every evening before going to sleep and really go into the experience of feeling connected to others. This will train me to be able to access these comforting

memories, when feelings of loneliness or abandonment are strong. The related schema could be abandonment."

What other experiential techniques for long-term change can you use to work on your VCM's sadness? Which schema would you be working on?

I am glad you can think of so many things. That is good work. Let's write them all down, so you can pick from different options the next time you want to work on VCM.

Do this for all modes on the handout. Let patients volunteer and then rotate, asking the rest to give an example so that everyone who wants to has a turn to speak.

Go over the long-term Mode Management Plan for each patient in detail. What follows is an example of how we present the examples.

OK, now look at the last page. Here we want to develop a long-term Mode Management Plan for your VCMs that you can use for permanent change. OK, who is experiencing sadness in VCM? [Acknowledge people who are nodding. Choose one person.]

Is it OK if we start with you? [Wait for OK.] *Which three long-term techniques that we talked about today do you want to write down for your long-term Mode Management Plan for your VCM?* [Do this for all patients who experience sadness in VCM.] *OK, who is experiencing anxiety or fear in VCM?* [Acknowledge people who are nodding. Choose one person.]

Is it OK if we start with you? [Wait for OK.] *Which three techniques that we talked about today do you want to write down for your long-term Mode Management Plan for your VCM?* [Do this for all patients who experience anxiety or fear in VCM.]

[Group Ending:] *Great work today, everyone. So your* therapy assignment *from today's group is to use your long-term Mode Management Plan from today until our next meeting and try to fill in some more of the spaces. Here is the worksheet for next week. We were very happy to have you here.*

Goodbye – have a good rest of your day.

This script, with minor adjustments for content and to fit your group and style, can be used for Mode Management sessions 7–12.

4.6 The 12 Experiential Mode Work Sessions

This component of ST focuses on experiential or emotion-focused work. This is usually the work that patients, and often therapists as well, are less familiar with, so we have provided more *detailed sample therapist scripts* and *patient handouts* for this section. We begin in the usual sequence with the Maladaptive Coping Modes (MCMs). As with the other components of the program, there are two sessions for each mode. For the sake of clarity we will discuss both sessions for each mode at the same time.

4.6.1 Maladaptive Coping Mode sessions (EMW 1&7)

Experiential Mode Work Session 1: MCM 1 uses experiential exercises to facilitate patients experiencing the effects of their MCMs and to evaluate the effectiveness of these modes in getting their needs met.

Group Exercise 1: MCM 1 – the Experiential Focusing Exercise

In this first EMW session we begin with an exercise that can increase patients' awareness of any sensation, thought, or feeling they have while completing a short walk toward a peer. This exercise often triggers a person's default Maladaptive Coping Mode (MCM) as it is an unstructured exercise that focuses attention on a relative stranger. We don't tell patients any of this as we do not want to influence whatever their experience may be. (Use the Experiential Focusing Exercise Worksheet (EMW 1-MCM1) for patients to record their observations.)



Sample Therapist Script: Experiential Focusing Exercise

*Hello, I am glad that you are all here and I am happy to see you. As you know, this is the Experiential Mode Work Group and our focus today is on the MCM. We will be doing two different therapy exercises today. The first one focuses on your awareness and the second is a mode role-play in which all of us will play the various modes. In the last part of the session we will work on developing a safe-place image that you will eventually be able to use as an alternative to the MCMs. (*Therapist name T2*) and I will show you how it goes. I will give him/her the*

same instructions I will give you. "OK, T2, we have done this before – just take a place about 12 feet away from me. I would like you to take slow steps toward me and at each step stop briefly and just note to yourself any physical sensation, thought, or feeling that you are aware of. Don't tell me what you are noticing, but I will want you to write it down after we finish. I will not move. I would like you to stop when you are about three feet away from me – about right here (point to the spot). Now you can start.

T2 goes through the exercise to demonstrate the task. Therapists should try the exercise ahead of time to experience what your patients will. Remember to point out the three-foot point as some patients will walk right into you otherwise.

Sample Therapist Script

Are there any questions before we start? So please pair up now. You will take turns being the one who walks and the one who is stationary. The person who is stationary also should observe his/her sensations, thoughts, and feelings at each step the other takes toward him/her. After one of you has walked, stop, and each of you write down your observations. Then reverse the walker–stationary roles and do it once again.

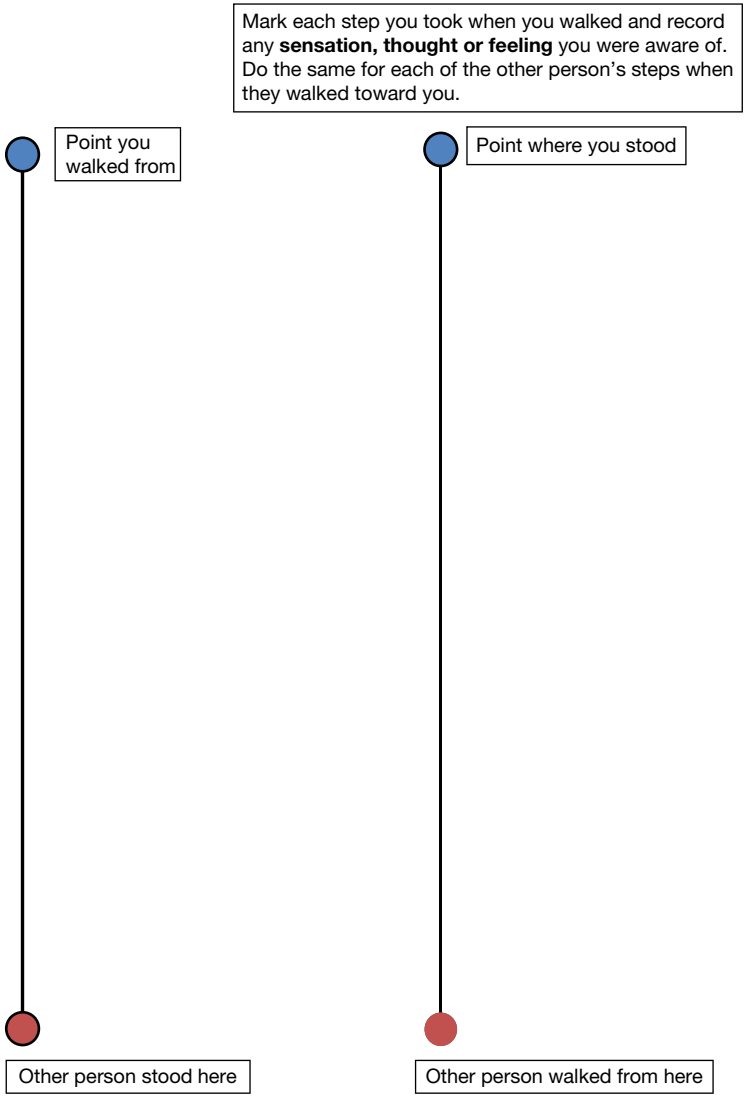
This part of the exercise takes about 15 minutes. If you notice people taking a lot of time with the writing part, you can give them a "minute warning." Patients do not usually take a lot of time for either the walking part or the writing. After all pairs have finished, call the group back together for discussion.

Were there any surprises for people? What sorts of experiences were you aware of? Which role did you like better – walking or stationary? Did anyone notice a mode pop up during the exercise? Sometimes an unstructured situation like this and a new person trigger one of the modes and help us learn about the mode in the safe setting of the group. [After a pause for discussion] *Good job everyone. Many of the exercises we do*

in the Experiential Mode Work sessions will be something like this – exercises that give us different kinds of experiences to be able to learn about our own modes and the needs that are underneath them. Any questions?

The experiential focusing exercise takes about 30 minutes.

Experiential Mode Work Exercise 1 – MCM: Experiential Focusing Exercise



Group Exercise 2: MCM 1 – the Mode Role-Play

The next exercise, the mode role-play, demonstrates the origin of the Maladaptive Coping Modes and how they function in the present in an experiential way. Patients and therapists play the roles of modes, thus having both an experience of the mode they play and how it feels to interact with the other modes. This is an experiential version of exercises like pro-and-con lists as participants experience the positive and negative effects of being in various modes themselves. You may want to change which therapist takes the lead in the next exercise. Both will have significant roles as the role-play develops. There are diagrams in the therapist notes that can also be used as visual aids in the discussion after the role-play.

Sample Therapist Script

In this next exercise we are going to do a role-play in which all of us take on the roles of the different modes to demonstrate and experience how they function. Before we can start we need to have scripts for the various modes to use. You were given the assignment to write down your ideas of what the various modes might say. Let's look at those and T2 will write the scripts down on the white board (or flip chart).

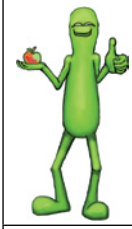
[Refer to **Experiential Mode Work Assignments 1 and 7: MCM 1 and 2 (**EMW 1&7-MCM1&2) for mode scripts. Patients should be given this assignment before this session, for example, in one of the ST Education groups.]

Experiential Mode Work Assignments 1 and 7 – MCM 1 and 2: Scripts for the Schema Modes

Write down examples of what you think each mode would say.

Avoidant Coping Modes 	

Overcompensating Coping Modes 	
Compliant Surrenderer 	
Vulnerable Child 	
Angry Child 	
Punitive Parent 	

○	Demanding Parent 	
	Healthy Adult 	
○	Happy Child 	

Gather script lines for each mode from the patients and write them on a whiteboard or flip chart. This allows you to gently correct any errors in their understanding of the modes and gives them scripts to use when they are playing the modes. Start with the Maladaptive Coping Modes (MCM). Choose two from those represented in your patient group. Don't get too complicated – basically Avoidant Protector, Compliant Surrenderer, Overcompensator. T1 plays the Healthy Adult Mode (HAM) and directs the action. This makes the point that the HAM is actually in charge of the modes' actions. T2 plays the Good Parent (GP) who is trying to reach the Vulnerable Child Mode (VCM) to protect, reassure, and soothe him/her.

Sample Therapist Script

I'm going to play the Healthy Adult Mode. This mode is the director of action and all the other modes must follow my instructions. T2 will take the role of the "Good Parent" and he/she will have the task of reaching the Vulnerable Child Mode with some of the statements we came up with as the script for that mode. Now we need volunteers for the other roles – we will need two to play the MCM modes, a VCM, an ACM, a HAM in training, and a GP in training.

At first, ask for volunteers for the roles. Begin with the more difficult roles – the VCM, PPM, MCM. This ensures that you will not be left with the most difficult role still to be assigned and the patient who is last to volunteer or does not volunteer at all. If a patient volunteers for a role that we think might be too much for them to handle, we subtly veto it. Saying something like – "*Gee, Sara, would you play the coping mode instead this time as you have become really aware of that mode for you and I think that would work out well for what we are doing*." The role to avoid having a patient *who is already in the Vulnerable Child Mode* play is the VCM, as it is too stressful for an early session. Typically, patients will volunteer for roles they feel able to play without huge difficulty. If too much distress is triggered, you can stop the action and do something to help reduce the distress. We have not found this to be a difficult exercise for patients, rather quite illuminating of the modes and helpful to their understanding of the ST model. It can also have fun elements.

The MCMs are selected to be representative of those predominant in your group. We give the PPM actors a mask of some kind so that they do not come to be seen as their role. Patients in the PPM roles do not usually report difficulty playing them as they are familiar to them. They do sometimes report it being painful when they see the reaction of the VCM. This is an experience we want them to have in order to build compassion for the VCM. If a patient protests that they don't want to take a role, you can first ask them if they will be one of the helpers. If they still decline, you can ask them to take the role of an observer and pay attention to how the modes interact and the outcome, or even to rate your job in the HAM role. When that is the only role a patient will take, we substitute that for the HAM in training. Whenever possible, we want everyone to have some role, however small, as we want them to stay connected.

OK, so let's have a volunteer for the Avoidant Protector and the Overcompensator. Remember, your original job was to protect the VCM from the PPM. So, you will do that using the script we developed. We need two of you to play the PPM and use that script. We are going to give you masks to use for the PPM roles as we don't want anyone to confuse you personally with that negative role. Who feels able to take the VCM role today? The VCM feels whatever feelings are present. Alright, thank you. And the Angry Child Mode (ACM)? The ACM tries to get attention paid to the VCM need, but does it in a way that is too extreme and gets him/her into trouble. Great. Now we just need a HAM in training to shadow me and a GP in training to shadow T2. You (HAM in training) can borrow some strength from me as needed to set limits on the PPMs. You (GP in training) will shadow T2 and model his/her actions. OK then, let's put you all in your places. The VCM sits over here with the ACM next to you. The DPM and AP will sit in front of you, but facing away from you as they are focused on the PPMs. Let's put the PPMs over here about 10 feet away. T2 as GP and the GP in training will sit next to each other about as far away as the PPM. Now each of you in training stay next to your model.

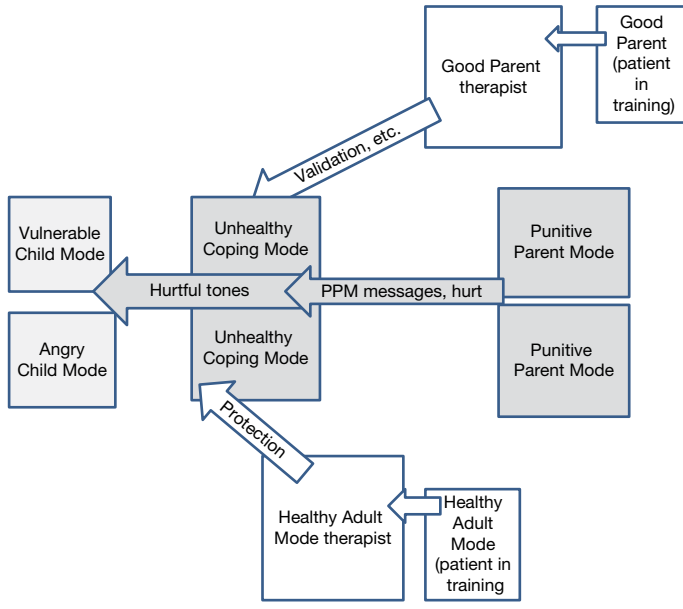


Figure 4.1 Mode role-play of schema modes in action. Scene 1: This is how modes develop and how they function now

> *Now, remember that the HAM, me, is like a movie director. When I give a direction or stop the action you must follow my directions. That is also the job description for the HAM.* (Figure 4.1 presents Scene 1 and shows how modes develop and how they function now.)
>
> *The first thing we will do is a demonstration of what these modes were like in your childhood. That means that at the count of 3, I want each of you to be in role and say your script lines from the board, adding other statements in role if you like. 1, 2, 3 – go.*

Let the ensuing chaos go on for a few minutes and during that time as the director encourage the ACM to get louder, the PPMs also, and whatever other coaching is needed from you. Then stop the action and discuss what happened.

> *OK, now everyone stop. Just take a breath. Let's talk about what happened. We will start with the VCM – was your need taken care of? Were you protected? ACM – were you heard? MCM – did you hear what the VCM said – he/she was not protected? That was your job, but it seems that you failed at it. Did you even hear the VCM? Were you aware of his/her need? PPM – do you think you were effective? GP – were you able to reach the VCM or ACM? So what we just saw demonstrates how the modes came to be and how they function now.*
>
> *However, as the HAM, there is a correction I need to make before we try this out again. The PPMs are way too close as they are not physically present anymore, they belong back in the past, so I am going to move them out of here* [take PPM actors to a far corner of the room]. *Your voices have become much lower now. I am going to leave my HAM in training here to make sure that you stay in the past.* [Leave that patient near the PPM, but facing the VCM.] *Now let's see what happens with the PPMs placed where they belong. I want everyone else to stay where they are and say your lines again.* [Let this go on for a few minutes then stop it.] (Figure 4.2 provides a diagram of step 2.)
>
> *OK, what happened that time? It wasn't a whole lot different, was it? So the PPM is gone, but the MCM are still facing toward them and focused on them. Now they are just keeping the T2 GP from reaching the VCM. Does the VCM or ACM feel any*

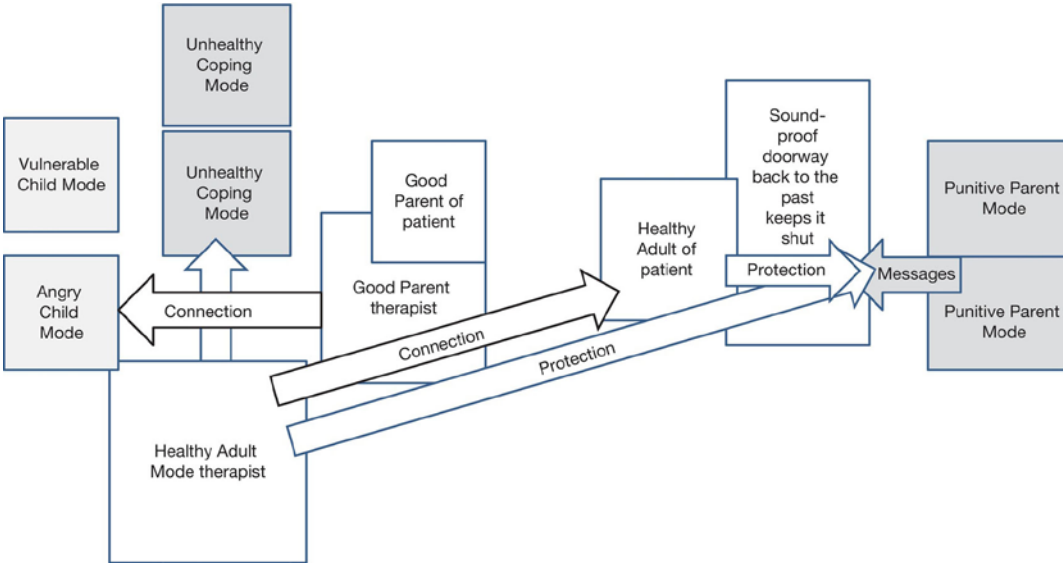


Figure 4.2 Mode role-play of schema modes in action. Scene 2: This is what begins to change during Schema Therapy

> *more heard?* (The VCM may say he/she is a little less scared as the PPM is less loud, but his/her needs are still not met.) *So, we need to make some more changes. How can we help the GP reach the child modes? Oh, so you think that we need to do something with the MCM.* [To the GP:] *What do you think we need to do?*
>
> [T2 becomes more active as GP.] *I think that the MCM could move away from the ACM a little bit so that I can get closer, but still stay on guard near the VCM. Would you do that?* (The MCMs will argue some.)

The GP's goal is to convince them to move over by reassuring them that she will listen to the ACM and they can be on reserve in case a survival situation occurs and they are needed again. The GP also tells them that they did a good job of ensuring the VCM's survival as a child and that was very hard work, but that they don't have to work so hard today as the HAM is there for that purpose and so are you. At this point, T1 as HAM can tell the PPMs to get a bit louder to test things and help the HAM in training shut them up again. This demonstrates that the PPMs may pop up again, but can be sent away as they truly do not have the same power they did in the past.

The GP now connects with the ACM and listens to him/her, validates his/her anger, and connects by giving him/her the end of a towel or piece of fleece and tugs on it a bit with him/her like a tug-of-war to help release some anger. Next, T2 asks the MCMs to move away from the VCM so that he/she can be reached. T2 moves closer to the VCM, gives him/her an edge of the cloth to concretely connect to him/her. This positive nurturing interaction goes on for a while and the GP in training is pulled into it and is coached to say a few validating things (the script constructed earlier can be referred to).

T1 leads further discussion of the experiences of each patient in the mode they played and what they observed. At the end, T1 gives a kind of summary of what has occurred and links it to the course of change in ST. Figure 4.3 presents Scene 3 and the healthier mode configuration.

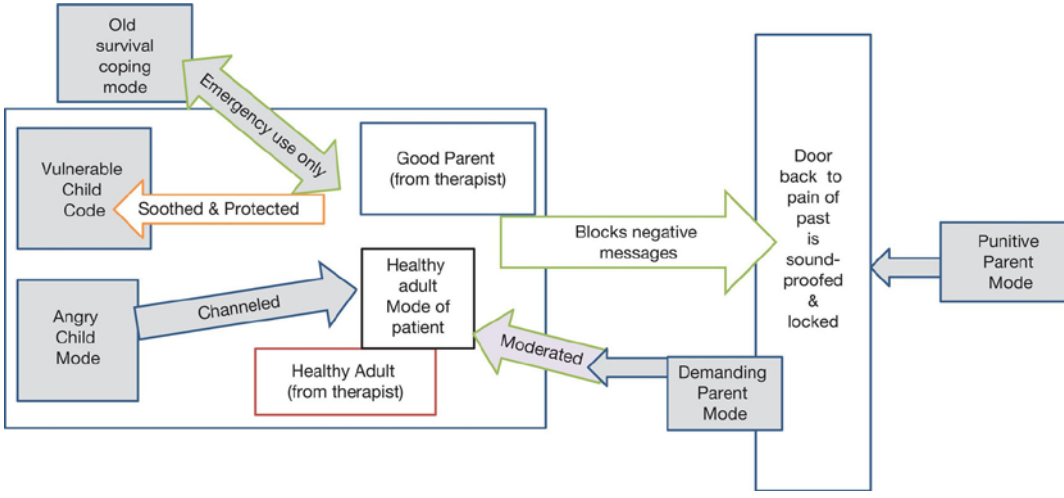


Figure 4.3 Mode role-play of schema modes in action. Scene 3: The results of Schema Therapy

> *OK, let's pull our chairs together again as a group and discuss this experience. So we saw how the MCM originally developed to keep the PPM away from the VCM, and they accomplished that, but in the process they did not hear what the VCM actually needed. As time went on, the MCM just kept everyone away and the PPM was long gone physically (sometimes even deceased). The ACM expressed the VCM need also, but no one heard him/her either. The GP could not reach the ACM or VCM until the MCMs moved to the side a bit. The HAM convinced them to stand at attention but move over. Then the GP could reach both child modes and do what a good parent should have done in their childhood. That allowed both the ACM and VCM to become less distressed and they could connect, which was their need. So this demonstrates for you what we are trying to do in ST in a nutshell.*

This role-play exercise is usually quite powerful for patients. It helps them understand the way the modes work at a different level than the cognitive. They often remark that now they "get" some of the modes that they had not understood previously. The discussion can be guided in a number of directions based upon the modes dominant in your group. If there is time left over, you can do a list on the whiteboard about deciding to reduce one's use of the MCM that captures what you all observed in the role-play and provides the cognitive intervention that supports the experience they just had.

Group Exercise 3: MCM 1 – the Safe-Place Image

This is an image also used in other therapy models in which imagery of a safe place is used for distress reduction. A difference in the ST version is that it is completely individualized with no assumptions that a beach or forest or other scene will necessarily feel safe for an individual. Some patients, particularly those with BPD, will tell you they have never felt safe anywhere. The image should be one that meets the VCM need for safety.

Therapist Tip

We help the group come up with a safe-place image by offering what our safe places are. JF talks about being at her grandmother's house in her flower garden or up in her attic sitting on a cedar chest. This often elicits a patient with a grandmother image as this is common. We brainstorm with the group for those who say they cannot think of one. We list many of the things that we have heard from BPD patients over the years: school, a particular teacher's classroom, a safe relative, a friend's house, a tree house, up in a tree, climbing a mountain, a trip to camp, riding your bike, an imaginary place like Oz, with a fairy godmother, at church, and so forth. We can honestly tell patients and you that we have always found a safe-place image for every patient, possibly because we expect to and will stick with it until we do. Keep in mind the possibility that someone will have had a bad experience or even been abused in one of the safe-place images given as an example. If that happens, it is important *to acknowledge that we "are all different" and sincerely say some version of the following statement: "Oh, that is awful, you certainly won't want to use that one*."

We use a variation of Young's basic instructions for the safe-place image (Young, Klosko, and Weishaar, 2003). With a warm, soothing voice we ask them to close their eyes or look down and to be aware of what it looks, feels, smells, and sounds like in great detail. When we first work with the safe-place image we do not specify the age or mode of the patient, just that it is a place where they felt safe.



Sample Therapist Script: Safe-Place Image Instructions

You can use your image to soothe your vulnerable child or reduce high distress or to replace the upsetting images of flashbacks. Let an image come to mind that represents a safe place to you. Don't push it; just be open to whatever safe image occurs. It can be like a movie scene, slide, photo, or it may be an actual memory. It can be something from your life, imagination, a book or movie. You can bring anything that is safe and comforting into your image. Make it your own. Don't worry if

you have some difficulty at first getting a strong image. We will discuss it in group and help you develop an image that works for you.

1. *What do you **see?***
2. *Can you see yourself?*
3. *How old are you?*
4. *What else do you see?*
5. *What **sounds** do you hear?*
6. *Does it have a **smell?***
7. *How do you **feel** in this place?*
8. *How does your **body feel?***
9. *Is anyone else there? Remember, only safe people are allowed.*



***Self-talk** for the safe-place image: "I am safe," "I control this space, no harm comes to me here,"* and "*I feel calm.*"

Add your own words _____.

Name your safe place so that you can bring it to mind quickly and easily. For example, "Grandma's house, the Tree house at home, Mrs. Smith's classroom." _____

_____ ”

We give them the instruction to practice the image at least once a day. We also suggest that they create a visual representation of their safe-place image, by drawing one, or finding a picture in a magazine, or symbolize it so that they can put it where they will see it regularly.

Experiential Mode Work Assignments 1 and 7 – MCM 1 and 2: Safe-Place Image Practice



○ It requires practice for your safe-place image (SPI) to get stronger and more useful as a healthy coping substitute for the MCM. Record your practice on the form below and the situation, mode, and result when you chose to use the SPI.

Day	*Situation*	*Mode*	*Result of SPI*

Once the safe-place image has been established, we begin group with a short exercise using it instead of the safety-bubble. If the group is doing very difficult work, struggling in some way, or we want to reinforce the group's connections, a safety bubble around all of us in our safe-place images can be added for extra safety and protection. In that case, we also mention the shared strength of our connections with the group. This begins the addition of the group to imagery that will become important when we are doing imagery change work for the Vulnerable Child Mode.

Experiential Mode Work Session 7 – MCM 2 focuses on giving patients the experience of the HAM and the MCM interacting and ultimately the HAM taking over the MCM's function of protecting the VCM and allowing his/her needs to be met.

Group Exercise 4: MCM 2 – the Mode Dialogue Role-Play Expanded

This time we want to give patients both the opportunity to play their own MCM and then to be in the VCM role when another patient is playing that same MCM. To allow all patients to have multiple opportunities to

play different modes, there is only one exercise for this session used in a number of variations. Since most patients have more than one MCM, it should be possible to divide the group up into at least two MCMs and more if needed. Then pairs of patients can take turns in the MCM or VCM roles with the other patients and the therapists taking all of the other roles in the manner described in detail for Experiential Mode Work Session 1. Before you start the mode role-play you can have the patients who will be playing the same MCM break into a small group to work on the script for that MCM. They can use the script from Session 1 as reference and add to it. The variant they will be working with may not have had a script made and in that case they have that task. The therapists can help as needed.

Only have one patient in the Dysfunctional Parent role and let them choose PPM or DePM. That will leave a patient over to take the Happy Child Mode. This time, have a patient volunteer take on the Healthy Adult Mode role and the Good Parent Mode role. One therapist should take the role of HAM's helper and take on the task of directing and stopping the action. The other therapist can take the Good Parent helper role. That role assignment allows the therapists to be coaches to the patients in the healthy roles. These changes give patients the opportunity to experience a variety of different modes.

Sample Therapist Script

Hello, I am glad that you are all here and I am happy to see you. As you know, this is the Experiential Mode Work Group and our focus today is on the Maladaptive Coping Modes. Today we will be working with the mode role-play again. So remember the HAM is the director of action and all the other modes must follow his/her instructions. The "Good Parent" role has the task of reaching the VCM with some of the messages we have identified as important over the last sessions. The MCM tries to protect the VCM by focusing completely on keeping the PPM or DePM away. If there is an ACM, he/she reacts intensely to the VCM's unmet needs. So let's get our various positions in place and get ready to start.

At this point in treatment we would not expect a patient to refuse to play a role. If they do, as before ask them to be a helper to the HAM or GP. If they still decline, you can ask them to take the role of an observer and rate how effective the various modes are in their jobs.

> *The first thing we will do is let the modes all play their roles and see what happens. That means that at the count of 3, I want each of you to be in role and say your script lines, adding other statements in role if you like. 1, 2, 3 – go.*

Let the ensuing chaos go on for a few minutes. Remind the HAM patient to direct the volume of the modes in their role. Then stop the action and discuss what happened.

> *OK, now everyone stop. Just take a breath. Let's talk about what happened. We will start with the VCM – was your need taken care of? Were you protected? ACM – were you heard? MCM – did you hear what the VCM said – he/she was not protected? That was your job, how do you think you did? VCM – how did he/she do at protecting you and meeting your needs? MCM – did you even hear the VCM? Were you aware of his/her need?*
>
> *How did it affect the role-play that the PPM was more out of the picture? Was the PPM less intense? Let's make it that way for the next role-play we do.*
>
> *GP – were you able to reach the VCM or ACM?*
>
> *How was this the same or different from the last role-play we did?*
>
> *OK, now that we have seen the way the modes were functioning now – let's allow HAM to make some corrections.* [To the patient playing HAM:] *What do you want to change – for example, do you want to put the PPM out the door? Do you want to move the MCM out of the way? And so forth.* [Make these corrections] *Let's go again and see what happens with these changes.*
>
> [Continue in this manner until all patients who want to have an opportunity to play the MCM and the VCM. Encourage patients to alternate playing the HAM. Coach the HAM and GP patients as needed.]

The goal of these repeat role-plays is to give patients experiences of being in mode roles as parts of their mode system change. The therapists will need to direct the discussion by asking questions to bring out the aspect of change. For example, *what happens to the VCM when the MCM is farther away?* The answer may be that the GP can reach her, but it feels a bit scary as it is not what he/she is accustomed to.

> *OK, let's pull our chairs together again as a group and discuss this experience.*
>
> 1. *Were the VCM's needs met?*
> 2. *Did the MCM step aside?*
> 3. *Was the PPM banished? Or was the DePM moderated?*
> 4. *Was the ACM heard?*
> 5. *Did the HAM make sure the VCM's needs were met? Did HAM do a better or worse job compared to the MCM? How was it different?*

The discussion can be guided in a number of directions depending upon your group's needs and modes. If there is time left over, you can again do a list on the whiteboard about choosing to reduce one's use of the MCM that captures what you all observed in the role-play. One would expect it to be different than the first time this exercise was conducted in **Experiential Mode Work Session 1: MCM 1** as patients will have increased awareness of their mode experiences and improved management of unhealthy modes.

4.6.2 Dysfunctional Parent Mode sessions (EMW 2&8)

When working with the DyPMs, therapists can focus on the mode which is most common in their group, or spend some time on both the Punitive Parent Mode (PPM) and the Demanding Parent Mode (DePM). The two parent modes are different as the PPM focuses on punishment and may or may not have high standards. The DePM focuses on unrelenting standards and constant work to improve, but may not be punitive. Of course, many of our patients are burdened by having both, and tend not to make fine distinctions between the two. There is a different approach to each in ST, however, as the PPM is banished, seen as having no positive value for the patient, and the DePM is moderated by transforming its unrelenting standards into reasonable ones.

Group Exercise 1: DyPM 1

The first exercise we use – the "Punishment Experiment" – is designed to contradict the belief of many patients that the PPM is "necessary" and even helpful for their performance. This exercise demonstrates the negative effects of DyPM messages on performance, contrary to what patients are taught and tend to believe. After the usual "Welcome to today's Experiential Mode Work group message," put the work you will be doing with the Dysfunctional Parent Modes into context with the following:

Sample Therapist Script: Punitive Parent Messages

Often when we talk about the PPM, patients tell us that "punishment is necessary" for children to learn or that "demands and pressure" make children achieve more. Does anyone here believe that? [Follow with these additional questions if necessary] *Even a little bit? Or you believe it but think that we won't want you to, so you aren't raising your hand?* [Short discussion of this content – 5 minutes] *Well, today we are going to do a short experiment to investigate the effects of the Parent Modes on performance.*

Sample Therapist Script: The Punishment Experiment – 20 min



OK, we need everyone to divide up into pairs. I have enough dowel rods here (a piece of wood rounded and 14–20 inches long, or some other object that can be balanced on a hand with some level of difficulty) *for every pair to take one. Now the task is simple: you just need to balance the rod on the palm of your hand for about one minute. It needs to be the flattened palm or it would be too easy and you could just hold onto it. So one of you goes first, and the first time you attempt to balance, your partner will play a PPM. That means he/she will tell you what a loser you are, you can't even do this right, you won't be able to do it, and so forth. We will observe how that affects your performance. The second time you try to balance the rod, your partner will play a Good Parent. That means he/she will encourage you, tell you he/she believes in you, you can do it, don't give up, and so forth. We will also observe the effect of that script on your performance. So one of you will start first being the balancer of the rod with the other the PPM and then GP, then you'll reverse roles. After you finish, we will get back together and talk about the results of our experiment.*

Discussion:

- What does your Vulnerable Child *feel* about the exercise?
- What does your Healthy Adult *conclude* from this exercise?
- How could your Healthy Adult act to limit the damage to your VCM from the PPM?

We give patients the handout Experiential Mode Work Session 2 – DyPM1: Punishment and Reinforcement: How Do We Learn? (EMW 2-DyPM1) to keep as a reminder of this experience and evidence to use to contradict their DyPM messages.

Experiential Mode Work Session 2 – DyPM 1: Punishment and Reinforcement: How Do We Learn?



○ The Punitive Parent says: "When people make mistakes, they need to be *harshly punished*! That is the only way they will learn! Otherwise, they will keep making stupid mistakes and harm other people or annoy me …."

Is this really true? Is harsh punishment really the only or best way to learn? Let's look at how punishment actually affects people. There are two main forms of punishment: either taking pleasurable or even necessary things away to punish kids (e.g., you are not allowed to watch TV today or no dinner for you) or unpleasant things are done to them (e.g., you have to sit quietly for a long time, or you are beaten). Both things make kids learn not to do the "mistake" again … but … *the punishment method has other unhealthy effects*.

○ The exercise we did in group demonstrates the downside of punishment. When people get punished, they start feeling bad about themselves and often think they are incompetent. They get really scared of trying again and will avoid doing new things. Now take a close look at children … children need to explore the world, find out what they like and dislike, and

form their own conclusions about how things work. This has to be done by trial and error and requires having a safe base in the form of an early caretaker. The child can explore from their safe base, and return to it if they need help or something seems scary to them. A good parent provides a safe base.

In contrast, the punitive parent might be disinterested (withdraw attention), which could make the child really insecure in exploring the environment or the punitive parent would punish it by saying things like "Don't touch that. You are such a bad kid for always walking away."

A good parent on the contrary would reinforce the child for exploring. The good parent would, for example, make eye contact, pick the child up, when it wants to be picked up, or say things like "Wow, what are you looking at there?" to express interest in the child. The good parent might even go look at things with the child. And if the child made a mistake (for example, run too fast, hurt themselves and cry), instead of punishing it more, a good parent would soothe their child.

Punishment is not the same as healthy protection or limits and naturally occurring consequences. Parents need to inform kids, depending on their age, about the consequences of their actions in the outside world. For example, if you steal something at a store, the police will be called. If you skip school, the school gives a penalty and you may not learn things you need to, and so forth. If you yell at friends and hit them, eventually they won't want to be your friend. We all have some consequences for our actions.

Good parents provide guidance about what the consequences of actions are and guide their children to make good choices. Parents will dislike some actions and tell children not to do something again. If a person or animal is hurt deliberately or the property of someone else is damaged deliberately, progressive limits need to be set to stop the behavior. This is true in therapy also – there is support for trying things and realistic limits when needed.



Harsh or extreme punishment in childhood is the foundation for the Punitive Parent Mode. A harshly

punished child learns to be punitive to themselves and to others, including possibly their own children.

If the "mistake" was a normal child need like hunger, asking for a hug, or asking for help, then the punished or ignored child may learn not to act to get their needs met or to ask for help. Those experiences can be the foundation for the Detached Protector or Angry Child Modes developing.

If the "mistake" was healthy child exploration or curiosity, punishing this can lead to an adult who has an undeveloped or unstable identity. That child can become an adult who won't know what they like and dislike, what makes them happy, or even what is bad for them.

Group Exercise 2: DyPM 1 – Getting Rid of Dysfunctional Parent Mode Messages

After we have created some doubt in patients regarding the value of the PPM, we move to the next step – facilitating them having the experience that their internal DyPM is not him or herself, but something that was taken in from early experiences and can be gotten rid of with some work. One of the ways that we demonstrate this experientially is the construction of effigies to represent the DyPMs. Using a tangible representation serves a number of therapeutic purposes. It demonstrates the theory of ST that this is an internalized negative object, *not* the patient and usually not completely a parent. The first step in eliminating the DyPM is the patient understanding that it is not his/her voice. Patients typically draw a face on the effigy, which looks like a monster or demon. This characterization is useful as it does not even look human, underlining the point that the DyPM is the selective internalization of only the negative aspects of caregivers, not the whole person. This is helpful for two reasons: patients don't think that they have to separate completely from their actual parents and from any good present in those relationships, so abandonment fears are not stirred up, and we do not run into family loyalty issues as much. The DyPM effigy evokes a lot of emotion, beginning at times with fear, but moving on to anger and rejection.

We first use the effigy as a site for patients to write the negative messages from the DyPM on. This process is another concrete action

to get the messages out of the patient. We have them think about getting rid of the message by leaving it on the effigy. We later use the DyPM effigy in mode role-plays as a mask for the patient playing the DyPM, or it can be draped over a chair to add realism to a mode dialogue in an individual session. The figure can be stomped on and even torn apart. Throughout the experiential group sessions we keep the effigy available but out of sight in case patients come up with another message to leave on it. The therapists always take it away at the end of sessions. These actions demonstrate at a child's developmental level that the DyPM is powerless now to do harm. The "Good Parent" figure therapists can easily control this effigy DyPM. In Experiential Mode Work Session 7 – DyPM2 we will describe using the effigy in mode dialogue role-plays.



Sample Therapist Script: Dysfunctional Parent Mode Messages



In the ST Education sessions we told you about the normal needs of young children and the effects of not having those needs met. We also talked about how we internalize what the important people around us in childhood say about us and how they describe us and how these messages stick, whether they are accurate or not. To give you an example [substitute an example here from one of the therapists that is not too extreme] – *I received the message from my mother that I was "difficult." I am not sure whether she said it in those words, but that is what I remember as if that was a direct message from her. Based on that message – whenever I had problems with people close to me I said to myself "oh, this is happened because I am 'difficult.'" At the cognitive level it developed into a core belief about myself and at the emotional level when I had that thought I felt queasy in the pit of my stomach. I came to understand as an adult and in my own personal*

> *therapy that this "difficult" label was not really about me, it was about my mother. I was "difficult" for her, because I spoke up.* I was not like her – *and that made me difficult for her. I discovered that many people appreciated that characteristic, but my mother did not, so I got that label. That message is part of my Demanding Parent Mode (DePM; and it is one I am alert for so that I can fight it if it comes up). So what we are going to do first today is talk a bit about what the negative messages are that you have from your DePM or Punitive Parent Mode (PPM) and then we will start our work to get rid of them and learn to fight them.*

Facilitate about 10 minutes of discussion. Usually patients have little difficulty coming up with negative messages about themselves.

> *OK, so now we are going to get rid of these messages symbolically and literally by writing them on an effigy we will make to represent the whole group's Dysfunctional Parent Modes.*
>
> *First we need to draw a face for our effigy*. [The cloth, muslin or other inexpensive fabric, has been cut into the shape of a large person, or can be a rectangular piece to have the body drawn on. We encourage patients to be involved in drawing some part of the effigy, but do not insist on this. We always try to let patients move at their own speed in the experiential work.] *Wow, that is one monstrous Dysfunctional Parent we have made. I guess that makes sense, because it isn't really one person or even a person, rather what is left with us from negative experiences with authority figures in the form of the parent modes. Now the fun part: we can leave any PPM or DePM messages we have on this effigy*. [Patients are encouraged to write messages on the effigy using cloth markers the therapists provide. Sometimes patients are slow in getting started, so we often start. Fairly quickly most patients do get involved.]

Once the effigy is completed, one of the therapists can demonstrate its current powerlessness. Allow 30 minutes to construct the effigy.

Group Exercise 3: DyPM 1 – Things a "Good Parent" Would Say to a Loved Child

This is one of the foundation "group as a whole" imagery rescripting exercises we use.

Sample Therapist Script: Good Parent Message

OK, so now we are going to switch to something positive and healing for your VCM. We will replace those negative messages you just got rid of with the ones you needed to hear as a child. Please take out your Experiential Mode Work Exercise 3 – DyPM1: Fighting the Punitive and Demanding Parent Modes: Things a "Good Parent" Would Say to a Loved Child (EMW 2-DyPM) *and take a few minutes now to write down the messages you would like to have heard from a loving parent as a child. Let's hear what people chose. What is your favorite one? I'm going to write all of them down so that we can make a group "Good Parent Message Script."* [Allow 25 minutes.]

The assignment asks that the language be young child level (e.g., "I love you just the way you are," "You are precious to me," "I am so glad you are my kid," "You are a really great kid," "I will always be here for you," "I will protect you." If it is something older like "I am proud of your accomplishments," translate it – for example: "You are just great" or "I'm happy that you are my kid." They bring their list into the group and we discuss their messages. We get their permission for the group to borrow ideas and statements from each other, as invariably some will say that they could not come up with anything. While patients are sharing their choices, the therapist is writing them down to construct a collective "Good Parent" script.

1. *Before we begin I am going to put the safety bubble around all of us. Let yourself feel the warmth and protection of the bubble for all of us. Remember that we will keep your VCM safe here. Now connect with your VCM. Do that in whatever way works for you – you can think of a picture of yourself as a young child or connect on a feeling level – however you are able to make that connection is fine.*
2. *I want to tell you some of the things that you should have been told by a loving parent and any other people taking care of you in childhood. I really want your Vulnerable Child Mode to hear these things as they are things that all little children need to hear and deserve to hear.*

Then one of us reads the script in as warm, soft, and caring a voice as possible. We add in some of our own "Good Parent" messages. It is particularly important for the therapist who is not reading the script to add a number of statements to the script.

> 3. *I want you to really hear me and be open to taking these statements in. If you get interference from any Punitive or Demanding Parent Modes try to kick them out, tell them they are not allowed here – only Good Parents can come into our group space. Try to remember the things you are hearing that you like best, because we are going to do something special with them. If you have trouble remembering, don't worry; I have it written down and will help you remember.*
>
> [When the script is finished:]
>
> 4. *Come back slowly to the group, remembering what you heard. We will discuss what this exercise was like for you.*
> 5. *Could you take it in from your VCM?*
> 6. *What did you hear that you liked best?*
> 7. *Were there any surprises for you?*
> 8. *Was there anything you had trouble with?*

The group discusses the experience, how they felt, could they stay in their Vulnerable Child Mode, what did they like best, and so forth. You can give patients an audiotape and/or a written copy of the script to listen to, re-read and carry with them. The assignment after this session is to do something once a day to remember the experience of listening to the Good Parent Script.

Experiential Mode Work Exercise 3 – DyPM 1: Fighting the Punitive and Demanding Parent Modes: Things a "Good Parent" Would Say to a Loved Child

Come up with a *list of things that you think a good parent would say* to a young child they loved and that you either heard or would have liked to have heard as a child. Try to use "kid language." Your Vulnerable Child still needs to hear these expressions of love, comfort, protection, and validation. Example would be: "I love you," "I am glad you are my kid," "You are great," and so on. We are going to use these statements in a creative way in a group session, so please give this some thought and write down some things. Feel free to borrow anything you have heard in groups, from therapists, and so forth that your VC liked. *We will compare notes and add to the lists in the Experiential group session for the Vulnerable Child Mode.*

I like hearing or would like to have heard the following as a child and my VCM still needs to hear: Write more on the back if you like.
1.
2.
3.
4.
5.
Add to your list anything you hear in the EMW-2 group that your Vulnerable Child liked:


Transitional objects

To help patients recall the Good Parent Script and to aid internalization, we give them transitional objects in connection with this exercise. The use of transitional objects is consistent with the attention to developmental learning level of ST and is used as an adjunct to limited reparenting. We use things like a soft piece of fleece, with or without a scent the therapists use, a special bead from each therapist on a piece of cord, a note with their Good Parent message on it. The Good Parent Script and other messages to the Vulnerable Child Mode can be made into flash cards, poems, songs, drawings, or any other transitional object that is tangible and can be available outside of therapy. We ask patients about their use of comfort blankets, stuffed animals, and so on, as a child. They usually had something and many also have a story of their parent throwing it out and feeling

devastated. We tell them that just as they are developing and being able to access a "Good Parent figure" in themselves, transitional objects from the therapists and group can remind them of comfort that they have experienced in imagery exercises or just from being in the safe accepting environment of the group. The first time we use a VCM transitional object we give them the rationale presented below. This is a good example of appealing to both their HAM and VCM.

Sample Therapist Script: Transitional Objects



Very young children must develop the cognitive ability to know that a parent exists if they cannot see them. Until they develop "object constancy" they have intense separation anxiety. The next step in healthy development is internalization and the ability to evoke the soothing image of a parent when he/she is not physically present. This is how the ability to self-soothe is developed. Children often have their blankets as transitional objects that remind them of the soothing from the parent, being tucked into bed, for example, with a soft warm blanket. Having that tangible object that represents the parent helps them feel the parent is real. The feelings of pain, fear, loneliness, sadness, and so forth that you become aware of when the VCM is triggered and that is not followed by an MCM taking over go back to the childhood experience of not having normal childhood needs met. We are working in imagery to supply those experiences to your VCM. It makes sense that we would also want to give you transitional objects for your VCM. These objects can help your VCM make the transition from comfort and soothing coming from the outside (e.g., therapists, significant others) to being able to provide it from the inside – the HAM in you. So, over the course of the group we will develop together various representations of the group and the therapists for your little children to use for comfort and reassurance. This is just another of the ways that we can help you correct as adults things that you missed as a child. Today we developed a Good Parent Script for the group and each of you recorded it or will get a copy to keep. We are also going to give you a little piece of soft fleece to help you remember this experience and to use when you listen to the tape. In one of the Happy Child weeks you will make a VCM soothing box or treasure chest to keep these things in. Did any of you have something like that as a kid? I know I did – it was an empty cigar box that my grandfather gave me.

We buy soft fleece from fabric stores and cut it into squares for this purpose. We choose patterns with hearts or other designs that are not over-identified with one gender. Men in the groups often kid about the fleece, but we notice that they also leave with a piece of it. Some groups make a larger group blanket of fleece to keep in the group room to share. They sometimes write Good Parent messages on it.

Experiential Mode Work
Assignments 2 and 8 – DyPM: Practice: Recalling the Good Parent Script

Your assignment from today's group session is to:

1. Practice letting your VCM hear the Good Parent Script and take out your fleece while listening.
2. Step 2 is to just have the fleece with you in a pocket or purse and use it sometime during the day when your VCM is triggered or you just want to feel it for soothing.

Write about what you tried and the result:



One of our patients actually made a Good Parent representation that was big enough to wrap around herself, like getting a hug. She wrote our names on it with things we had said to her VCM and drew pictures of us on it. It looked like a large person with arms that could be wrapped around your body. She felt that it was very soothing and reassuring for her VCM.

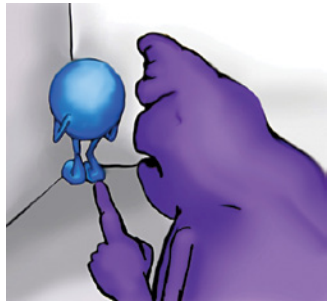
The assignment from this session is to use the transitional object, go to a quiet place alone and recall the experience of hearing the script and write about the experience.

Experiential Mode Work Session 8 – DyPM 2

> *Group Exercise 4: DyPM 2 – Whole-Group Mode Dialogue Role-Plays*
>
> This session focuses on whole-group mode dialogues or role-plays in order to give each patient time to have one focused on their specific needs and content. We prefer mode role-plays to imagery rescripting for challenging and banishing the DyPM as a group mode role-play involves everyone actively and feels more powerful. Rescripting is easily done in the individual sessions. The DyPM banishing role-play can be adjusted to match a patient's pace. A fearful patient in VCM with little connection to the HAM can observe and see that nothing bad happens. They can even observe someone else banish their DyPM. This kind of vicarious learning can be an important first step for avoidant and anxious patients. Depending upon their need, patients can position themselves behind the therapists for safety, be part of the group supporting the "banisher," or they can stand directly with him/her. While observing, the patient should be in whatever degree of safety he/she needs – for example, safety bubble, covered up, holding co-therapist or other member's hand, and so forth. The "banisher" may start out with the therapist speaking to the DyPM for him/her. Patients can begin to speak from the safety of the group when in the VCM and then in stages move to the front as their Healthy Adult gains strength. The tangible experience of the collective strength of the group effectively combating and eventually expelling the DyPM has powerful effects in diminishing the intensity of this mode. We have seen patients begin in fear, take in the group's strength, and move in the same session to confronting their parent from the Healthy Adult. We use the effigy as a mask for the person playing the DyPM. We do not want any residual DyPM "energy" attached to the patient who plays that role. We want the Punitive Parent to remain something "not human" that was taken into the Vulnerable Child and needs to be eliminated. We do not have either therapist play the DyPM role.

We are working to be seen as the "Good Parent," so playing the DyPM has the potential to be too confusing at the level of the child modes. Be sure to check after DyPM work that group members feel safe before leaving the session. Create contingency safety plans if they have safety concerns. Finish the session with a longer return to the safe-place image or safety bubble that includes the instruction that the DyPMs are safely locked away.

Sample Therapist Script: Mode Dialogue Role-Plays – DyPM



Hello, I am glad that you are all here and I am happy to see you. As you know, this is the Experiential Mode Work Group. Today we will be using the mode role-play again, but this time we will be banishing the Punitive or Demanding Parent Modes (PPM or DePM). This role-play is set up a little differently. How many of you feel that you are at the point where it is time to banish your PPM (substitute DePM throughout the session if that is the mode you chose to work on)? Great. Well, to do that one at a time we are going to have a dialogue between you and your PPM. This is something that it is best to do from the strength of your Healthy Adult Mode (HAM). It is also something that you can have as much support as you need for. You can have the support of other group members, the therapists, a whole army.

We will need someone to play your PPM and another to be a support to that person. The person playing the PPM will have the effigy to use as a mask so there will be no confusion that it is not them personally, but just a role they agreed to play.

There is also more than one way to banish the PPM. If you do not feel ready to do it, we can play all of your mode roles and let you observe us doing the banishing. Does everyone understand what I mean by that?

Who would like to go first as the banisher? Who feels able to play the PPM behind the effigy? Who will support the person playing the PPM? You notice that I did not say support the PPM, rather the person playing that role.

Let's set the rest of us up so that everyone feels safe enough and the banisher has enough support. [Have a few people move chairs near the banisher.]

If any of you are in touch with your VCM, this could seem scary. Why don't any of you feeling that way come over and sit behind me and T2? We want everyone to have what they need to feel safe doing this.



OK – [to the banisher] *Tell your PPM what you want to say to it*. [This is done and the PPM answers back. We let the PPM answer back up to three times. If needed we jump in, asking the banisher if we can also speak. We want to tell the PPM how much they have hurt the VCM. We do not debate the PPM or let the "poison" of its messages out onto the VCM of the patients. We stop the action and turn to the banisher and say some version of: *I think that we have heard enough. It is time to throw this old _____(expletive – bitch, bastard, etc.) out!* [One of the therapists takes the effigy away from the PPM and gives it to the banisher.] *You can throw it against the wall, out the door, stomp on it, whatever you like. It has no power now. Can you feel that?*

This experience is processed with the whole group and then repeated with a different patient as the protagonist. Those who have not taken a turn should be offered a number of more supported options. One example is the therapist speaking to the PPM for them. As stated earlier, another is to have the group and therapists play all the roles. End the session with the therapists reading the Good Parent Script that the group developed previously. For an assignment repeat Experiential Mode Work Assignment 2: DyPM1.

4.6.3 Vulnerable Child Mode sessions (EMW 3&9)

The VCM sessions focus on imagery work, as this is the major experiential intervention of ST for healing the Vulnerable Child Mode. It is important to give patients a rationale in understandable language for why we use techniques like imagery and imagery rescripting. We include basic information about how imagery works and the research validating its effectiveness, so that they can be open to trying it. We pave the way for more difficult

imagery with the early "fun" images and safety mages. The safety images remain important tools throughout treatment and as a healthy coping tool for use in life.

Experiential Mode Work Session 3: VCM 1



Sample Therapist Script: Imagery Rescripting

Our memories of childhood are not happening right now, rather they are images that we have stored of perceptions, feelings, sights, sounds, thoughts that we have connected with childhood events. Even though they are not "real" in the sense of "happening right now," when we bring them to mind it can feel like they are happening now *and it causes emotional pain. In imagery we can change the ending of painful memories by creating in your image* what should have happened, *if the protective, strong "Good Parent" you deserved had been there. Just as we all can re-experience pain and fear when negative childhood memories recur, we can also experience comfort, protection, and care when we bring the "new ending" into our mind in imagery. The mind works like a slide projector that puts one image at a time on the screen of our awareness. In imagery rescripting, we are changing the slide you put in the projector for that particular situation. This may sound like magic, but it is supported by scientific research. Imagery rescripting is an effective way for people to heal from traumatic childhood memories. One of the most important things we take away from events is* what we think it means about us *that the event happened. So if we are not protected and bad things happen to us as children, the Vulnerable Child part of us interprets that to mean that we are bad. As children we are not capable of understanding like an adult can, that the real problem is not that we are bad – the problem is that* no one was there for us. *We had the normal needs of a kid, but no one was there to meet them. Unfortunately, every time you remember these painful childhood events the feeling of being bad comes along too. That means that years of practice have made it very strong and we don't question it anymore. Experiencing rescripted memories of having a loving, protective Good Parent will affect how you think about yourselves.*

We have been questioning the assumptions you made about yourself as a kid in the ST Education group. We have looked at how we form beliefs about ourselves and others and life based on how our needs were met and then we don't question them – they are our reality.

> *Some of you have reached the point where you are beginning to be able to say "In my head I know that I am not bad or evil, I was just a kid with normal kid needs and they were not met because no one was there." However, we have also talked about how you still* feel like you are bad *in some way. That is the part we work on in imagery – that you* still feel *unworthy, bad, a failure, too needy, or whatever other messages you internalized.*
>
> *Our goal now is to give your Vulnerable Child part a good parent to protect, comfort, nurture, love, teach, and all those things kids need. We will approach this work in small steps as we do not want to have you feel overwhelmed or re-experience bad memories again. We want to stop painful memories* before anything bad happens. *We want to rewrite the ending, so that nothing bad happens in the image. We also want to teach you how to stop re-experiencing bad memories when they start up outside of therapy.* [Allow 15–20 minutes including discussion.]

Unfortunately, many patients are very reluctant to try to connect with their Vulnerable Child Mode. They typically have negative and rejecting feelings toward their little child part that must be addressed and ultimately challenged.

Therapist Tip: VC

Inevitably someone asks "Why do we have to do this?" or says "I hate that kid, he was the source of all my problems, he was a bad kid." Our answer to the first question is always some version of "*You need to do this because the only way to get unstuck emotionally and not keep living with the consequences of not getting core emotional needs met* (use their words: how you were mistreated – neglected, abandoned, etc.) *as a child is to go back to that time experientially and help that part of you heal.*" To the second question we say, for example: "*It was not your fault as a little child that your needs were not met. Young children are not 'bad' if they are getting their healthy normal emotional needs met*" *or "Is that how you feel about the Vulnerable Child Mode of your peers here?*" Often the answer is no, which allows us to say: "*Your little child is just as worthy of love and care as the rest of us. I think that we are hearing a Punitive Parent Mode (PPM) voice right now and we will not allow any PPM here when we are working with the VCM. We need to get those PPM messages out of here.*"

The VCM is first reached with safety imagery (in Experiential Mode Work Session 1), then "Good Parent Messages" (in Experiential Mode Work Session 2), and finally imagery rescripting. Imagery rescripting allows us to meet the VCM in his/her childhood memory and rewrite the ending in such a way that his/her core need is met. We begin with situations in which the little child needed a "good parent" to meet a core need and no one was there. The patient begins to feel the original pain that is in a sense frozen in the VCM and with imagery we have the opportunity to create a new experience and a new memory. This usually takes the form of protecting the child, comforting him/her, or telling the DyPM to stop, that they were wrong to treat him/her like that, and then taking the child in imagery to a safe place. Eventually the childhood memories weaken as the patient has the experience of having core needs met. Patients begin to feel as well as understand the legitimacy of their little child's needs and the "goodness" of that part of them. They experience that childhood wounds can heal. The VCM may always have some schema triggers related to abandonment, emotional deprivation, and punishment, but the healing attachments that were not made back then can still be made now, thanks to the brain's amazing plasticity. Another way that schema mode change occurs is the process of experiential "antidotes." Many mode-healing experiences for the Vulnerable Child Mode take place in response to emotional validation, acceptance, kind treatment, and respect in the group. These experiences create feelings of being worthy that contradict early maladaptive schemas that developed from core needs for validation and acceptance not being met in childhood.

We do not begin to talk about the HAM aspects of meeting patients' needs until well after they have experienced feelings of protection, comfort, validation, acceptance, and love in the safety of imagery and the experience of the group's healthy family environment. Only after this missed step in attachment and emotional development has been accomplished, and a "good parent" has been internalized, are patients able to meet their own VCM needs in a meaningful way. The distinction about who comes into imagery work to change the scene (e.g. to protect the child) is a very important one. Cognitive therapy approaches (e.g., DBT; Linehan, 1993) assume a "healthy adult" already present in the patient and pull for self-care from the patient from the beginning of this work. As discussed in earlier chapters, that is not the approach of ST, whether individual or group. The modeling of a healthy adult and a "good parent" to the VCM by the therapist and the internalization that occurs in limited reparenting and imagery work are critical steps in ST that allow the development of a HAM.

Group Exercise 1: VCM 1 – Rescripting a Childhood Experience of the Therapist

Sample Therapist Script: Group Imagery Rescripting

We will begin by giving you an example of how imagery rescripting works by T1 sharing a situation where he/she needed a good parent in childhood and no one was there in that role. We will ask you to observe the situation.

Using self-disclosure in this way allows patients some distance at first in imagining the therapist's childhood situation and facilitates their self-disclosure. It shows them how we do imagery rescripting and reduces their apprehension. It also demonstrates that we all have modes and it can make the therapist seem more real and genuine, thus fostering the connection with her.

1. *Connect with your safe-place image (SPI). We will stay there 1–2 minutes. I want you to remember that your SPI is there for you and you can return to it any time you want to in the session today. OK, open your eyes and come back to the group.*
2. *I am going to tell you about a time in my childhood when I needed a good parent and no one was there to fill that role for my VCM. What I would like you to do is imagine yourself* (here fill in details from your own scene) *outside of a souvenir store looking in through a big picture window that allows you to see everything that happens inside. I was 6, in a little souvenir store picking out my souvenir from the family vacation. I really looked forward to that because I collected souvenirs and it was one of the ways I connected with my mother who was not very emotionally expressive in general but excited about her collection. I found a snow globe that was within my dollar budget, but when I picked it up it was slippery and I dropped it. It smashed and splattered everywhere. The store owner yelled at me and made me pay for it with the one dollar I had. My mother was there and did nothing to help or defend me. I was devastated, but didn't cry because we were with my uncle and my cousins and I was embarrassed. I felt like a bad kid, that I had made a terrible mistake. It also gave me the message that I would be all alone if I got into any trouble.*

Group discussion has patients sharing what they observed. The other therapist asks them questions like:

3. *What do you think T1's little child felt and what did he/she need?*
4. *What would a good parent have done differently?*

Encourage them to ask any questions they have about the experience. T1 also tells them what the link to a problem of moderate level in current life is.

5. *As I tell the memory it doesn't seem so big, but I know that it is related to my unrelenting standards schema and part of why I still have a big reaction today when I make even a small mistake. I have worked on it and I catch that reaction (which is a good example of my PPM), but it still pops up sometimes.*
6. [The second therapist leads this part of the imagery work. T2 begins by asking the group:] *How can we work together as a group to change the ending now? Let's brainstorm.*
7. [T2 says:] *Now*, (name of T1), *can you go back into the image and connect with little X and this time the rest of us will join you? I am going to play not T1's mother, but a good parent, and I want the rest of you to be there watching and see how our script affects little T1. Watch what happens to the little child's face when a good parent defends and comforts her.* [T1] *OK, let's go back to just after the snow globe smashes and I'm there as the Good Parent* (T2 plays this role dramatically). *Oh, T1, honey are you alright? Let me get you away from this broken glass. Poor baby, are you hurt anywhere? Don't worry, you are not in trouble – it was an accident.* [To the shopkeeper firmly:] Stop – *do not yell at my little girl! Can't you see that she is upset, she is a child and you have no right to yell at her? Talk to me about this. I am her mother and I will be responsible for any damages.* [To T1] *It's OK dear, you didn't do anything wrong, it was an accident. I know that you really wanted a snow globe, I think they are pretty too.* [To the shopkeeper:] *Here is $2.00. One dollar for the broken one and one for the new one you are going to bring out for my little girl. The shopkeeper pulls a new one out from under the display – and it slips out of her hands and breaks.*

> [T2 in the role of a Good Parent says:] *See, all of us can have accidents.* [To the shopkeeper:] *I hope that you have another one, but if not there are a lot of other stores here we can shop in.*

The group and therapists come out of the image and discuss what they observed. This is an opportunity to underline how a good parent would act and the very different effects when T2 played the mother. T1 shares what the rescripting was like for him/her. The joke we threw in to the example is not required. We add it to show that we can still have some playfulness to balance doing difficult work; many patients report liking that part best.

Group Exercise 2: VCM 1 – Group as a Whole Imagery Rescripting

In shifting to rescripting patient memories, we start with a short image that introduces the therapist entering the image with the patient observing the interaction with the VCM.

Sample Therapist Script

1. "*OK, I want you to go back to a time in childhood where you are in a situation as your Vulnerable Child Mode where you needed a "good parent" and no one was there. Just focus on whatever comes to mind as a time when you really needed a good parent to be there for you.*"

Judging by their nonverbal behavior, we let the group go for two minutes or stop sooner if there is too much overt distress. In this early work we want patients to realize that they can visit uncomfortable memories for a short time and not be completely overwhelmed.

2. *Now open your eyes and come back to the group and let's talk about what situations you remembered.*

We try to get everyone to share something from their experience. If someone does not come up with one, suggest they may think of one as we talk more and they should feel free to add a memory later. Next, we go back to the uncomfortable image. If someone has brought up abuse or trauma, have them go back to the point before anything really bad happened.

> *OK, go back to that image just for a minute or two and really be aware of what you needed as that little child.*

Have them again come back to the group. This is good practice in asking for needs directly. Also, it ensures that we will know what needs to be met in their imagery when we go into it as the Good Parent figures.

> *So now briefly tell us about your image – who was there, how old were you, and so on. What were your needs?* We encourage them at this point to continue using "I" language.
>
> *Go back now to that same image as your little child. Be your little child.*

Sample Therapist Script: Being a Good Parent for All of the Group Members' VCM

Listen to my words and take all of them in for your little child. Imagine me coming into your image to be the good parent you deserved, to comfort and protect your little child. Just listen to what I say to your little child – I am here so you don't have to be scared. I'll protect you. No little child should be left alone like this. You are precious and deserve protection.

Now imagine me coming into the image to meet whatever your little child needs. Whatever your child's needs are, I am meeting them. Try to just take in the experience of having your needs met as your little child. Know that I will ask nothing in return, there is no price tag. You are a young child who needs some care, deserves to have his/her needs met, and I am giving that to you. I know that your mommy and daddy did not always understand you and realize that you needed affection, love, protection, and so forth. What you need to know is that you deserved those things – all children do and you did too. Just because the adults around you could not give that to you does not mean that you did not need and deserve it. The little child part of you is the part that feels emotional pain. The little child needs to feel some of the nurturance and comfort that she did not get in order to heal and not feel so wounded. When this happens you will not feel as much pain. Imagery work is the

> *way to reach early memory and repair faulty feelings of being wrong and bad that come from early experiences. You were not bad or wrong, those experiences were bad and wrong and it was wrong that you were not protected. We all know that children should be protected.*
>
> [Pass around squares of soft fleece.]
>
> *The fleece we are giving you now is for your little child. It represents the softness and comfort that we want to give her and that she deserves. Use the fleece to remember our healing work with your little child. Let it represent the needs that she deserves to have met.*

Here we have made the *transition to him/her being the child*, not just seeing him/her.

> *Now when you open your eyes, try to let your little child be present and take in the circle of little friends that you have here. These are friends who will not purposely hurt you and who know the pain that you carry and struggle with.* [Give them a few minutes.]
>
> *Let's talk about what you experienced.*

After each image, we process the experience as a group. This processing is an integration of the cognitive and experiential aspects of the imagery change work. The therapist pulls out themes to support the overall idea that the child was mistreated, did not deserve that treatment, was not bad, the parent was wrong to treat a child so harshly, and so on. Ask about any mode interference they experienced –for example, PPM messages, Detached Protector.

The assignment for all of the rescripting sessions is to practice returning to the rescripted image. We give patients a simple form for this assignment as we find that if we do not, the assignment is more likely to be forgotten. We also want them to be accumulating evidence about the effects of rescripting.

Experiential Mode Work Assignments 3 and 9 – VCM 1 and 2: Practice: Imagery for the Vulnerable Child Mode

1. Practice connecting with your safe-place image and allowing your little child part to be there.
2. Go back in memory to hearing your therapist describe a new ending in which your VCM was protected and cared for. Fill in all the details that were important to you.
3. Let yourself imagine or see that scene in whatever way works for you.
4. If any Punitive Parent Mode interference pops in, send it off into space in a bubble or put the PPM under a glass dome that no sound gets through.
5. Keep your piece of the fleece with you in a pocket or purse and use it sometime during the day when your VCM is triggered or you just want to feel it for soothing.

Write about what you tried and the result:



Experiential Mode Work Session 9: VCM 2
Start the session with the customary positive greeting and ask the patients to make sure that their connection to their safe-place image is in place. We suggest this to reinforce its use as it is one of the ways they learn emotional regulation and distress management initially.

Group Exercise 1: VCM 2 – Little Child Alone on the Street

The next imagery exercise is one that we use both to assess the relationship between the patient and the Vulnerable Child Mode (VCM) and to develop some compassion for him/her. It is also the first step in the transition to the patient starting to find his/her inner Good Parent, which we see as the part of the Healthy Adult Mode (HAM) that will eventually care for his/her VCM.

Sample Therapist Script: Little Child Alone on the Street

We would like you to close your eyes or look down and try to imagine the situation that we will describe to you. Just be aware of any thought, feeling, or mode that is present.

1. *You are walking down the street toward your home and you see a small child ahead of you. Your first reaction is that she is too young to be out alone, only 3 or 4 years old. As you get closer to the little child you notice she is crying and hanging her head down. When she sees you, she keeps her head down, but raises a hand up to you in an imploring way.*
2. *You take her little hand and start telling her reassuring things – like you will find her mom, she is safe, and so forth.*
3. *You decide to take her home with you so you can call the police to help locate her family. She very willingly goes along with you, holding your hand. She stops crying and smiles at you.*
4. *How do you feel? What do you do? How do you continue to try to take care of her?* (If there are both genders in your group, change to he/she.)

In the ensuing discussion point out the various Good Parent skills that patients used with this little stranger. Next, have them once again close their eyes and listen to the image you describe.

5. *So once again you are leaving your home and you see a little child sitting in the street crying. You walk up to her, telling her comforting things (you can use some from the discussion if you like). This time, as you get closer she raises both arms toward you to be picked up. You decide to pick her up and as you do you realize that she is you as a little child.*
6. *How do you feel? What do you do? How do you continue to try to take care of her?*

After a minute or two, have everyone open their eyes and come back to the group.

This exercise can be quite emotionally evocative. It is a first step in asking patients to care for their VCM. This exercise gives you information about how much or little compassion the patient has for their VCM. A number of our patients reported that as soon as they realized they were the child, they wanted nothing to do with him/her. A few patients even reported dropping the child. Some were able to continue taking the child home, but then said: "Since it is me, I do not know what to do with her." This is not due to a skills deficit, rather a discrimination error in not matching caretaking skills they use with others to meeting their own VCM need. Their responses provide openings to introduce the idea of compassion for the little child they were, who did not get needs met and needed love and comfort as much as the little stranger child on the street. Barriers to self-compassion can be identified – like faulty beliefs that their child is "bad," "undeserving of love," and so forth. You can go over some of the information from ST Education groups about all children deserving to have needs met and issues like how does a young innocent child become "bad" in their eyes. It can be useful to do the exercise again with the patients knowing it will be their child, with instructions to try to comfort and take care of the child like they would a real child of their own or a beloved niece or nephew or grandchild.

Therapist Tip: Coaching

At this point in the internalization process we act as Good Parent coaches as needed. If a number of patients have difficulty caring for the little child, you can repeat this exercise and go along with them to coach them in how to take care of their VCM. Make suggestions of comforting words, a shawl to wrap up in, rocking, a warm beverage, and any other Good Parent behavior you can think of.

The occasional patient says that they have "no 'Good Parent' in them." We have those patients come into the image to watch us again and suggest that they watch exactly what we do so that they can begin to build their "Good Parent." We see a patient's "Good Parent" as a representation of any good parenting they received throughout their life, including therapists and what they are getting from us in limited reparenting in the treatment program. The "Good Parent" is a building block of the HAM. After each image, we process the experience as a group to integrate the cognitive and experiential aspects of the imagery change work. The therapist pulls out themes to support the overall idea that the child was mistreated, did not deserve that treatment, was not bad, the parent was wrong to treat a child so harshly, and so on.

Group Exercise 2: VCM 2 – Imagery Rescripting Patients' Memories



Sample Therapist Script: Introducing Patients' Rescripting

Do all of you remember the VC session six weeks ago where we rescripted a time from my childhood where I needed a good parent and no one was there for my VCM? [Say some detail to remind them if needed.] *Did that example from my life remind anyone of a similar incident in which you needed a good parent and no one was there?* [Some discussion of examples] *Would one of you like us to work on your situation the same way we did for me?* [Usually someone volunteers. If not, you can do some gentle nudging by asking one of the patients who gave an example if they would work on that one.]

OK, we will go through the same steps as we did for the therapist example.

1. *Describe the situation.* [When they get to the "no one was there" part, be ready to stop them before details of abuse are shared and explain in a very gentle way that "*we don't want you to re-experience trauma –we want to stop before something bad happens to your VCM child and change the ending to what should have happened with a good parent there doing their job.*"]
2. *What does* (patient name) *VCM need? How could a good parent meet those needs in imagery? Let's form a plan.*

3. *OK, now go back to the point of the need and I will use the plan as a good parent would. We would like everyone to let your VCM take in the soothing and comforting things I will say.*
4. Have all come out of image and discuss their experiences, starting with the patient who volunteered their situation.

Sample Therapist Script: Ending the Session after Rescripting

I want to acknowledge all the hard work we have done today. I also want to end the group with a short Good Parent image for all of you. Just close your eyes and imagine T2 and I there with your VCM holding his/her hand in support. Now imagine all of the Good Parents of the group members, including yours, circling around us for support. Let your VCM take in all of the care and warmth and take his/her little hand in yours and give him/her a caring message from you. If that feels difficult, you can always say "I am learning that you deserved to be loved and cared for and to have your needs met."

Experiential Mode Work Assignments 3 and 9: VCM 1&2 is used for both sessions.

4.6.4 Angry/ Impulsive Child Mode sessions (EMW-ACM 4&10)

Experiential Mode Work Sessions 4 and 10 focus on the Angry Child Mode and Impulsive/Undisciplined Child Mode. The relative focus on each depends upon their representation in your group.

The group must be a safe place for the Angry Child to vent anger. It is important not to have Angry Child venting directed at a patient in Vulnerable Child Mode. A variety of anger release techniques are employed and these are fully described in the therapist notes. Doing Angry Child Mode role-plays requires making sure that all of the group feels relatively safe or measures can be taken to accomplish that (e.g., patients are behind the therapists, behind a wall of pillows).

Experiential Mode Work Session 4: ACM 1

Therapist Tip

It is important to distinguish the Angry Child Mode, which is a normal, instinctual expression of anger when needs are not met, from the Maladaptive Coping Modes like Angry Detached Protector or Bully-Attack. For the Angry Child, venting is therapeutic and meets their need to be heard. For the Angry Detached Protector, venting only serves to create distance and empathic confrontation is what is needed and therapeutic. With the Bully, venting will be directed aggressively at someone and the therapist's limited reparenting response in that case will be limit setting. It is also important within the child modes to distinguish the Angry Child Mode and Impulsive Child Mode, as they need different things in limited reparenting. It is important to separate the emotion of the Angry Child Mode from the action of the Impulsive Child Mode. As good parents we want to communicate our acceptance of the child and his/her feelings, but set limits on behavior.



Anger is very frightening for many patients. They associate trauma, abuse, pain, and fear at the mere mention of anger. Asking them to engage in play to deal with anger is met with great hesitancy, fear, and skepticism. However, games like tug-of-war, stomping, and popping balloons are a safe and effective way to release anger. Patients begin to realize that movement and play are good tools for releasing anger, and it feels much better than shoving it down and numbing out. Making sounds like who can make the best cow sound or the loudest pig noises is a game that is safe and fun. It can be the beginning step for the patients to claim their voice. Being able to say "Stop" and "No" when they are feeling anger can be taught through the use of play. Patients over time discover that nothing bad happens when they get angry and that they can control expressing the feeling and control the action. The exercises below can be used in helping to release anger or frustration, or to increase the energy level when the group has "shut down."

Sample Therapist Script: Anger Exercises

In introducing the topic of "anger" or "anger work," you can start with asking the question: *How many of you have ever had fun with anger?* This question usually brings silence to the room, or sounds of disbelief. In either case, you can respond with: *OK … a show of hands, how many of you have gotten in trouble because of your anger*. Most will raise their hands. Acknowledge this with a nod or a "*wow!" Well, today we are going to look at ways to have fun with anger, so everybody stand up*.

To keep everyone involved and connected and to decrease the likelihood of patients being triggered by the anger expression of others (hearing or seeing anger work being done), we give them the role of cheerleaders when they are not directly participating in an exercise. This pulls the group in and adds the fun element. There is always a good deal of play, grunting, and groaning through the exercise. Having the patients cheer keeps them active and focused on the demonstration.

Group Exercise 1: ACM 1 – Tug-of-War

(**Item needed**: large towel)

I need two volunteers. [Give each one the end of a large towel.] *Now, when I count to three, I want you to pull hard enough to lift the other off his/her chair. There is one rule – as soon as someone starts to be lifted up out of their chair, STOP. Now the rest of you have a role also. This half will cheer for patient A, and this half for Patient B. I want you to cheer loudly for your participant, saying things like: "Go Brenda Go" and "Go Linda Go" or "Pull, Pull." I also need two of you to act as spotters in case the "tuggers" get carried away and are coming out of their chairs – you will need to remind them to stay sitting, watching they do not fall*. [After everyone is in place:] *OK, are you ready to begin? 1, 2, 3 – GO*.

After this exercise, ask the "tuggers" how they felt doing this exercise and what it was like to hear the cheering. Ask the cheerleaders what they felt cheering. Time permitting, let each member try the exercise. Another option is to have group members pair up to try the exercise. Again, ask for feedback from those that tried the exercise. You can

point out how the muscles used to release anger in the tug-of-war game are the same ones we use when we hold anger in or are used in physical aggression. Often, when a person shoves down their anger, certain muscle groups are affected, like the shoulders, arms, back or jaw muscles. These exercises can help in releasing the body tension from these areas. Typically, at the end of the exercise the volunteer feels more grounded and, if he/she began the exercise angry, less angry.

Therapist Tip

In setting up these exercises it is important to structure in limits like "both people must stay in their chairs and when one is lifted off the seat, the exercise is over." A line could be placed on the floor for a tug-of-war involving more people. With therapists monitoring, these are safe exercises to access anger in a setting where it can be worked with. Exercises like this are very important for patients who fear anger – the experience of being able to access the ACM in a safe manner in which play breaks through their fear and "nothing bad happens."

Group Exercise 2: ACM 1 – Ball Making and Paper Toss

(**Items needed**: two old phone books, hand wipes, waste basket)

[Divide group into two teams and give each team an old phone book.]

> **Part One**: *Work as a team and try to outdo the other team by making the most balls using four to five phone book pages for each. You will have three minutes. On the count of 3, Go!* [Declare the winner.]
>
> **Part Two**: *Stay in the same team. Each team should have at least 12 balls divided equally. One member from each team will alternate turns tossing balls into the basket. Team with the most successful balls wins.* ***Toss the ball with your non-dominant hand***

Group Exercise 3: ACM 1 – Balloon Work

This is an exercise to help release anger or to use during times of general "stuck-ness." Give everyone a balloon and instruct the group members to imagine that they are to fill the balloon with either

angry feelings or thoughts (or with things that might be keeping them stuck), *but* do not tie the balloon off. On the count of 3, everyone raises their arm and releases the balloon into the air. The balloons fly around the room, causing laughter from the participants. Releasing even a little of the anger makes room or space for more pleasant feelings to enter in.

Balloons are needed for the next three exercises.

Group Exercise 4A: ACM 1 – Balloon Pop

Everyone is given a balloon to fill and tie off.

> *Place the balloon in front of your chair. Remain seated; try to break the balloon with your feet. Plug your ears if the sound is upsetting.*

Group Exercise 4B: ACM 1 – Balloon Pop

> *After filling and tying off your balloon, place it on the floor in front of you. Break the balloon from a standing position.*

Group Exercise 5: ACM 1 – Construct an Angry Child Mode Image

(**Items needed**: old magazines, scissors, glue, and poster board)



Have group members look through magazines with the focus on finding pictures and words that fit for the Angry Child Mode. Each patient can make a mode collage that represents their ACM using the pictures and words. Give patients about 30 minutes for this activity.

> *Come back to the group and present your collage and tell us a little about your experience making it – thoughts, feelings, if you were aware of the ACM – what effect did the activity have on him/her?*

Experiential Mode Work Assignments 4 and 10 – ACM 1 and 2: Anger-Release Practice

1. Try one of the Having Fun with Anger exercises from your session: for example – bat your PPM balloon around the room and finally burst it or sit on it.
2. Blow up a balloon with the idea that you are blowing into it all of your anger and frustration of the moment that is causing discomfort. Put the balloon in the closet or under the bed – somewhere out of the way – knowing that it will be there if you need to go back to it.
3. Do the paper wad – ball toss until you are tired.
4. Or try one of the other exercises from the sessions.

Write about what you tried and the result:



Experiential Mode Work Session 10: ACM 2



The Angry Child Mode reflects the innate response of a child to a need not being met. In this mode a person needs to be allowed to vent and be heard, within reasonable limits. It is important that we make it clear to patients that we are not afraid of their anger and that we will set limits on them becoming abusive if they are not be able to. This is reassuring for patients who fear their own anger as they have only seen anger be abusive and out of control with people being physically hurt. It is also reassuring for patients who are terrified of others' expression of anger because of experiencing abuse or others abused in their families. We frequently have patients say: "We dealt with a conflict and no one was killed!"

Therapist Tip: Anger Exercises

To keep everyone involved and connected and to decrease the likelihood of patients being triggered by the anger expression of others (hearing or seeing anger work being done), we give them the role of cheerleaders when they are not directly participating in an exercise.

Group Exercise 1: ACM 2 – The Push-Back Walk

Have group members match up into pairs trying to keep the height about the same.

> *One pair will start the exercise. For the rest of you, half will cheer for "X" and the other half will cheer for "Y." On the count of 3, begin pushing back to back; no using your butt, try to push the other person until they walk from their stationary position.* [* Spotters needed.]

Group Exercise 2: ACM 2 – The Punitive Parent Face



Everyone is given a balloon to fill and tie off, then, using markers, they are instructed to draw their Punitive or Demanding Parent Mode's face. After everyone finishes they are told they can bat the balloons back and forth to each



other, trying to keep them at first in the air by everyone trying to keep up balloons that come near them. Do this for about 12 minutes, then give the instruction that people can do whatever they want to the Parent balloon. Give about 5 minutes for this, then come back to the group circle and discuss what they chose to do with the balloon, what that meant to them and how they felt doing it. Inquire about any Parent Mode activity during the exercise.

Group Exercise 3: ACM 2 – Smashing "Eggs"

This is an exercise using imagery. Have the group imagine that they have been given a dozen eggs. On the count of 3, they are to imagine throwing the eggs against the wall, watch the yolk run down the wall, see the mess it is making. Discussion: what are some of their thoughts and feelings?

(Alternate exercise) Experiential Mode Work Session 10 ACM 2, Group Exercise 4: Group Stomp

Blow up and tie off 30 balloons and have everyone stomping at the same time.

Group Exercise 5: ACM 2 – Mode Role-Play

Another alternative activity, depending upon the needs of your group, is to set up the mode role-play of MCM 1 and let the ACM be the focus.

You could have the ACM interact with the PPM, with the MCM. You could have one patient play the HAM and the Good Parent and interact with the ACM. A wide variety of options can be implemented based upon the ACM of your patients.

4.6.5 Happy Child Mode sessions (EMW 5&11)

The main goal of the experiential sessions for the Happy Child Mode is that patients experience play with its exploration of likes and dislikes, first social interactions, and just being able to allow themselves to have fun. Patients are often resistant based upon DyPM messages. In ST, play is a powerful



tool that helps abused and emotionally deprived patients break through the blocks of mistrust and fear by providing safe experiences where they can feel and learn to trust. Accessing the joy of the Happy Child Mode can shatter the belief that they are "all bad." Play is an enjoyable experience for both the therapist and the patient because it is a safe way to attend to the needs of the Vulnerable Child, the Angry Child, and the Happy Child. The experience of play can be a reprieve from the prison of the Punitive Parent Mode.

Elements of play are easily introduced in the group setting. As the group bonds and forms the multiple overlapping attachments of a working psychotherapy group, the supportive atmosphere that is generated provides a comfortable mutuality that lends itself to play. In general, we use humor and a playful approach to GST work. It is a way to connect with patients that is independent of our formal roles, which fosters genuine human connections between therapists and patients. Given the number of triggering schemas they have related to their performance and evaluation, playfulness can become a welcome exchange that does not involve judgment. In imagery work we create images of play, fun, joy and have them practice accessing those along with the safe-place images.

Experiential Mode Work Session 5: HCM 1

Here are some suggestions of activities to use to evoke the Happy Child Mode (HCM). Feel free to adjust them as you like to fit your patient population or to develop your own. If you do the latter, please send us any exercises that work well as we are always looking for new ideas. Patients may have as much difficulty engaging in fun as they do with other experiential exercises. Dysfunctional Parent Modes or Maladaptive Coping Modes may be triggered. When this happens, it is important to discuss it and to intervene to banish the parents from this session or get around the MCM. So Happy Child work can involve dealing with interfering modes as well as setting up fun.

Therapist Tip: Introducing Experiential Exercises

How you set the stage in introducing an exercise contributes to its success or failure. Keep in mind that if you are unsure of, or questioning, an exercise, this will undoubtedly be felt and picked up by your patients. So as much as possible be energetic and enthusiastic when presenting an exercise. We have found that it is more effective to "*invite the group to do an exercise*" rather than ask them if they "*would like to do an exercise*."

Sample Therapist Script: Imagery to Evoke the Happy Child Mode

[Begin:] *I am so excited to see your smiling face and how your eyes twinkle. Hearing that wonderful giggle of yours and how it makes everyone who hears it join in with laughter. I love the sound of your laughter when it comes from the deep part of your belly. I love how your little voice changes in tone when you get excited. I love all your questions. You are a smart and entertaining little kid. You are very precious and deserve to be happy and to have fun and play. Thank you so much for sharing your Wonderful Happy Child with me.*

Group Exercise 1: HCM 1 – Creative Fun Exercises

Team activity: Play is our earliest experience of negotiating, meeting, forming friendships with others. When play is prohibited, people miss out on this foundation developmental experience. These group activities provide that experience and the various mode flips, feelings, reactions of patients can be discussed afterward.

Group mascot

(**Items needed**: general craft supplies, old hats, pieces of clothing, scarves, fabric, etc.)

Using any craft supplies, work together to create a group mascot. Your setting will determine what is available here. In some settings, play-doh or clay may be the limit of what is available to use as the medium. Other settings may have a wider range of possibilities. If an art therapist is part of your team, we suggest that he/she be invited to attend this session. Art therapists may be willing to assist the psychotherapists in leading the session and/or allowing it to be held in their work space.



Fun with the modes

(**Items needed**: old magazines, scissors, glue, and poster board)

Have group members look through magazines with the focus on finding pictures and words that fit a good parent. Each patient can

make a mode collage using the pictures and words that represent a "Good Parent," who would support the Happy Child Mode. Give patients about 30 minutes for this activity.

> *Come back to the group and present your collage and tell us a little about your experience making it – thoughts, feelings, if you were aware of the ACM – what effect did the activity have on him/her*?"

Group Exercise 2: HCM 1 – Fun for the Happy Child Mode in Imagery Exercises

> *Everyone take a deep breath and listen closely to my story. Allow yourself to become a part of the activity as if you were a child of 6 years old. Pay close attention to my instructions and your feelings while participating.* [Begin the exercise:] *Oh, it is so good to see all of you today. I have a very big surprise for all of you. We are going on an adventure to a huge toy store, the biggest in the world. Wow! I can see how excited this has made you. I am excited too. Once we get to the store you will each have three minutes to pick out two toys that you have always wanted. You do not have to worry about paying for it because I won the lottery and I want to treat all of you. OK, the time starts now, and the first room we enter is the stuffed animal room. Oh my! Look at the size of that panda bear, it almost looks real. Teddy bears in every size and they feel so soft, giraffes, puppies and kittens, there are so many different kinds and sizes of soft animals here. Only two more minutes left to pick your toys. I see some of you running off to the Game Room and I can hear lots of laughter and giggles. Oh look! There's a doll room with large and small dolls – Barbies, porcelain dolls in antique costumes, Madame Alexander, some of every type. There is a transformer room, battery operated cars, planes and trucks, science kits, magic tricks, and so many books. Someone just dashed off to the Disney room. One minute to go. Hurry, hurry! WOW! It looks like everyone was successful in selecting two toys. Let's go back to our group room and talk about what you picked and why and what feelings were you aware of. Any mode flips take place?*

You can add as many fun adventures in imagery as you like, following the format above. We include one imagery exercise in each of the Happy Child sessions. We want patients to have positive images to evoke when they need them to balance painful memories. We give them the therapy assignment of practicing evoking positive images.

Experiential Mode Work Assignment 5 – HCM 1: Imagery Practice for the Happy Child Mode

Practice evoking any of the positive images of fun, play, happy experiences from the Happy Child Experiential Mode Work session.

Keep a short record of which image you used. Build up your collection of happy memories to revisit to balance painful ones.	
M	
T	
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Experiential Mode Work Session 11 – HCM 2

Group Exercise 1: HCM 2 – Creative Fun Exercises

(**Items needed**: craft supplies, shoe boxes, decorative paper, crayons, markers, ribbon, scissors, glue, buttons, stickers)

The treasure box



Use a shoe box and have the group members decorate the box with items from the list. Explain how the box can be used to hold mementos from the group or small items they hold dear –keepsakes, memories, and connection boxes.

Our groups regularly make these boxes, which they use for the treasures of their "little child." Their collections consisted of small smooth stones or shell pieces from their therapists' trip to the beach, crayons, bubble gum, pictures, bags of scent, cards, and so forth. Therapists and patients write positive affirmations on cards. Patients make things for each other, tapes of relaxing music, book marks, and so on, all of which serve as transitional objects. The box is a resource they can take out for soothing; they can look at the "treasures," eat the candy, blow bubbles, and so forth. The box can be used to evoke the Happy Child or comfort the Vulnerable Child. Patients report that having this resource aids them in learning about comforting their "little child." From their Healthy Adult Mode they can comfort the "little child part" by reading a card from the box, telling him/her about the objects in the box and why they are special as you would do to a little child, play the tapes, and so forth. We emphasize to patients that it is not possible to re-do your childhood, but it is possible to respond as an adult to the unmet needs of the Vulnerable Child Mode.

Therapist Tip

Some patients struggle with the treasure box exercise because it activates their Punitive Parent Mode. We acknowledge this and, as the Good Parents, offer to keep the box safe for them until they have diminished the power of the interfering mode. You can also use imagery like that below to deal with the PPM.





Group Exercise 2: HCM 2 – Imagery Exercise to Banish the Dysfunctional Parent Mode

> *This is little* (fill in the name)*'s time to play and have fun, to be free and explore, to claim being a happy little child. All children deserve this time. You did not allow it when they were children, but you are not in charge now. In fact, I want you to get out of here. Didn't you see the sign on the door that said "NO NASTY PARENT MODES ALLOWED. ENFORCED BY THE MODE POLICE." So out the door with you and don't come back – there is no place for you here.*
>
> *OK kids, the place is yours again. Run, skip, play, explore the play room all you want. This is 90 minutes just for you. Set up a game if you want and everyone can join in, we therapists too. All of us have a Happy Child Mode that needs to have fun and learn about what he/she likes and dislikes.*

Group Exercise 3: HCM 2 – Happy Child Mode Dream House Imagery



> *Everyone take a deep breath, close your eyes a to connect to your Happy Child. Play close attention to my words and taking them in.* [Begin:] *There's a knock on the door and when we open it we see a large box sitting there addressed to: "All the Happy Children in this room." Let's open it together and see what it is. Oh wow! It is a beautiful miniature doll house. But wait! There's a note. [*Have your group turn this house into a dream house where they can each take a room to fill and decorate any way they want to. There is a separate room for each of you.*] Let us go to the*

miniature store and select the items you want for your rooms. Choose a paint color, or you might want wallpaper. Pick a soft rug. Don't forget big fluffy floor pillows and a game chest. You might want an artist easel or a table for scrap-booking or playing with clay. Now it's time to get the games and toys to fill your room. What did you pick? I can't wait to see your room when it is completed.

Ten minutes total. Call everyone back to present their room and discuss the experience.

Experiential Mode Work Assignment 11 – HCM 2: Letting Your Happy Child Play

1. This assignment is straightforward and uncomplicated: do something purely for fun. If you like – repeat something from the Happy Child Mode group sessions. It must last at least 20 minutes.



This assignment you do not have to write about – just allow your Happy Child within to play.

1. If another mode interferes (e.g., the Punitive Parent), push it away and try to stay focused on the fun that your little child deserved and you even as an adult also deserve.
2. What Good Parent message can you give your DyPM?



4.6.6 Healthy Adult Mode sessions (EMW 6&12)

In each Healthy Adult Mode session some time is spent giving patients the experience of playing the HAM role in a mode role-play. Another aspect of experiential work for the HAM is to anchor their experience of competence and the positive feedback they receive from fellow group members and therapists in a tangible object that can act as a stimulus to re-experiencing this in the future. We use what we have labeled an "identity bracelet." It can also be a keychain or other decorative object. We have found the bracelet to be a powerful reminder of the experience of worth, value, acceptance, and belonging in the group. It has been helpful to some of our patients who were most strongly in the grip of defectiveness shame schemas and the DyPM. We find that our patients still have their bracelets years later, sometimes wearing them or carrying them with them in a purse or pocket.

Experiential Mode Work Session 6: HAM 1

Sample Therapist Script: Introduction

> *Hello, I am glad that you are all here and I am happy to see you. As you know, this is the Experiential Mode Work Group. Today we are going to do a number of exercises related to the role of the Healthy Adult Mode (HAM). The HAM has important roles in relationship to all the other modes. For the Vulnerable Child Mode (VCM), the HAM role is to protect, comfort, and heal, providing a Good Parent when the VCM is triggered. For the Punitive or Demanding Parent Modes (PPM or DePM), the Healthy Adult banishes, repeatedly if necessary, the PPM, and moderates and makes more reasonable the DePM. Those are the two roles that we will work with today.*

Group Exercise 1: HAM 1 – Feeling the Effect of PPM and DePM Messages on the VCM

[For this exercise therapists need to have prepared a minimalist face of the VCM on a whiteboard or flip chart.]

1. *In the Experiential Mode Work PPM session you wrote PPM messages on an effigy. What we want you to do now is write the message that troubles you the most on a Post-It note*. [Therapists should do this too.]

2. *To demonstrate the effect on the VCM of our having these messages, each of us will go up and put the message on the VCM.* [Therapists should go first and place the messages right on the face as we want it to end up being covered.]
3. *What was that like?* [Expect painful, sad, or an MCM.] *Did anyone notice a mode flip when you did it?*
4. *Well, our HAM is not going to tolerate those messages burdening the VCM for long. Each of us will go up and take our PPM's message away and get rid of it.* [Therapists go up, pull it off, and dramatically wrinkle it up and toss it away. As patients do the same, the rest can cheer, led by the therapists.]



5. *What was that like for you? Did anyone experience a mode flip when you threw the message away? What mode do you think you were in taking that action?*
6. *So now the VCM can at least be seen.*

What our VCM deserved to hear:

7. *In this part of the exercise we are going to write as many Good Parent messages as we can think of on Post-Its. Think back to the messages you heard in the VCM session from the therapists and messages from the Good Parent Script. These are the messages that our VCM deserved to hear as a little child.* [For this exercise therapists need to have prepared a PPM face on another whiteboard or flip chart. This can be a circle with minimal features, but a line or unpleasant mouth.]
8. *OK, now we are going to each go up and smother the PPM with these messages. Here is the way our HAM can do it.* [Therapist goes up first to demonstrate.] *You should have said I was a wonderful child, you should have said that you loved me, and so forth.* [Therapist should do about six messages quickly. As he/she does so, the other therapist should start the patients' cheering at each positive message.]
9. *One at a time, patients go up to the face on the PPM whiteboard and smack the post it's on, saying with each one some version of "you should have said, you should have told me …"* [Other group members support and cheer.]

10. *We have managed to totally smother and wipe out the PPM. What was it like to do that? What mode were you in? Could you connect with your HAM?*

Messages from the HAM to the VCM:

11. *OK, the last thing we are going to do is write our most important HAM message to the VCM on a Post-It and go up and put it around the VCM. That will provide protection from the PPM.*
12. [Patients write one more GP message – the one that impacted them the most today. Each goes up to put it on around the VCM face.]

Group Exercise 2: HAM 1 – Short Physical Grounding Exercise

Are you aware of your HAM now? [If not, do a short imagery to connect.] *We are going to do a quick exercise to feel our HAM more. Stand up and really feel your feet and legs under you. Bend your knees just a little and feel your connection to the earth beneath you. Stand up really tall and feel your adult height. Take a few deep slow breaths. You are all strong, competent people who have survived a lot and deserve to heal the past. Feel your own strength and the support of the group around you.*

Experiential Mode Work Assignments 6 and 12 – HCM 1 and 2: Developing Your Healthy Adult Mode

One major way to develop your Healthy Adult Mode is to strengthen the *things that support positive thinking, coping and a plan for the future*. Many different kinds of things fit in this category: a supportive relationship, a picture of a supportive person, a picture or symbol that represents an important characteristic you have, a note of encouragement, and so forth.



Assignment

Identify, and then try, at least two of the following kinds of "Healthy Adult strengthening strategies." Write about what you chose and your experience with doing it.

1. Read aloud to yourself the encouraging words from others that you have written down. If you don't have any, ask people for them. You can use the words from the beads.
2. Practice a healthy coping skill
3. Hold a tangible object, smell a scent, or look at a picture that evokes a feeling or positive connection.
4. Revisit positive memories from your group experiences (e.g., imagery rescripting, feelings of connection in the web exercise, sense of belonging and acceptance). Imagine that your mind is like a slide projector – put in a positive slide of a memory and if a negative slide shows up, eject it and put the positive one back in. Remember that we don't have conscious control of every thought that comes into our heads, but we can do something about whether we let it stay or replace it with something else.
5. Visualize a dream you have for a healthy adult future.

- _____
- _____
- _____

Experiential Mode Work Session 12: HAM 2

Sample Therapist Introduction

Hello, I am glad that you are all here and I am happy to see you. As you know, this is the Experiential Mode Work Group and our focus today is on the Healthy Adult Mode (HAM). Today, we will be working with the mode role-play again.

Group Exercise 1: HAM 2 – The Mode Role-Play



This time we want to give patients the opportunity to play the HAM and experience trying to manage the other modes. This is done with one of the therapists playing a helper to the HAM. The role-play can also be stopped at strategic points when a dysfunctional or maladaptive mode is operating and the patient playing HAM does not know what to do. One of the options for the HAM that should be underlined is that he/she can ask for help. HAM can remind other modes to use various skills and antidotes that he/she has learned so far in the treatment program.

Solicit volunteers for the other roles: one Good Parent (GP), one Vulnerable Child Mode, one Angry Child Mode, one Happy Child Mode, one Dysfunctional Parent Mode (let them choose PPM or DePM), one or two MCMs. Have a patient volunteer take on the Good Parent Mode role. One therapist should take the role of HAM's helper and take on the task of directing and stopping the action. The other therapist can take the Good Parent helper role. That role assignment allows the therapists to be coaches to the patients in the healthy roles. These changes give patients the opportunity to experience a variety of different modes.

Sample Therapist Script

So remember the HAM is the director of action and all the other modes must follow his/her instructions. The "Good Parent" role has the task of reaching the VCM with some of the messages we have identified as important over the last sessions. The MCM tries to protect the VCM by focusing completely on keeping the PPM or DePM away. If there is an ACM, he/she reacts intensely to the VCM's unmet needs. So let's get our various positions in place and get ready to start.

At this point in treatment we would not expect patients to refuse to play a role. If they do, as before, ask them to be a helper to the HAM or GP. If they still decline, you can ask them to take the role of an observer and rate how effective the various modes are in their jobs.

> *The first thing we will do is let the modes all play their roles and see what happens. That means that at the count of 3, I want each of you to be in role and say your script lines, adding other statements in role if you like. 1, 2, 3 – Go.*

Let the ensuing chaos go on for a few minutes. Remind the HAM patient to direct the volume of the modes in their role. Then stop the action and discuss what happened.

> *OK, now everyone stop. Just take a breath. Let's talk about what happened.*
>
> *We will start with the VCM – was your need taken care of? Were you protected? ACM – were you heard? MCM – did you hear what the VCM said – he/she was not protected? That was your job, how do you think you did? VCM – how did he/she do at protecting you and meeting your needs? MCM – did you even hear the VCM? Were you aware of his/her need?*
>
> *HAM – how did you attempt to change the usual way these modes operate? How successful was your effort? What did you learn to use in the future?*
>
> *How did it affect the role-play that the PPM was more out of the picture? Was the PPM less intense? Let's make it that way for the next role-play we do.*
>
> *GP – were you able to reach the VCM or ACM?*
>
> *How was this the same or different from the last role-play we did?*
>
> *OK, now that we have seen the way the modes were functioning – let's allow HAM to make some corrections.* [To the patient playing HAM:] *What do you want to change – for example, do you want to put the PPM out the door? Do you want to move the MCM out of the way? And so forth.* [Make these corrections.]
>
> *Let' s go again and see what happens with these changes.* [Continue in this manner until all patients who want to do so have an opportunity to play the MCM and the VCM. Encourage patients to alternate playing the HAM. Coach the HAM and GP patients as needed.]

The goal of these repeat role-plays is to give patients experiences of being in mode roles as parts of their mode system change. The therapists will need to direct the discussion by asking questions to bring out the aspect of change. For example: *What happens to the VCM when the MCM is farther away?* The answer may be that the GP can reach her, but it feels a bit scary as it is not what he/she is accustomed to.

> *OK, let's pull our chairs together again as a group and discuss this experience.*
>
> 1. *Were the VCM's needs met?*
> 2. *Did the MCM step aside?*
> 3. *Was the PPM banished?* or *Was the DePM moderated?*
> 4. *Was the ACM heard?*
> 5. *Did the HAM make sure the VCM's needs were met? Did HAM do a better or worse job compared to the MCM? How was it different?*

Group Exercise 2: HAM 2 – Bead Exchange

In the last experiential group it is important to do something to symbolize the work that you have done that has contributed to strengthening the HAM. That is the overall goal of ST. We like to do a bead exchange. We supply a large bowl of glass beads that are very different in color, shape, size, and so forth. The patients some time earlier will have selected one for each member of the group to represent a HAM strength that they have observed in them over the course of the treatment program. They will also have prepared a small note card and written on it what the bead represents.

One person at a time will be given our beads and cards. These beads will be strung on a cord with the rest of beads the patients have accumulated from other experiential sessions. They should have approximately 14 beads, enough for a bracelet or key chain or "worry beads" to use for stress reduction. The beads are a transitional object representing what the members and therapists have seen in them and acknowledged through the course of the program.

Therapist Tip

Some patients have difficulty making eye contact or proclaim that they are too embarrassed to receive the beads. Here we push them to try to just take it in. *It is OK to be embarrassed as you are not used to all these positives, but it is an important experience for you to have.*

Sample Therapist Script

In the future you can wear this or keep it with you in a purse or pocket or in your VCM treasure box or safely stored somewhere. When you take it out and hold it you can remember the experiences you have had here that have strengthened your positive sense of yourself and your HAM.



The assignment for Experiential Mode Work Session 12: HAM 2 is to repeat **Experiential Mode Work Assignments 6 and 12: HCM1&2**.

The patient handouts, exercises, and assignments for each of the group sessions presented here are also provided in reproduceable form, which can be accessed on the companion website at www.wiley.com/go/farrell.

5

The Individual Schema Therapy Sessions

The content focus of the individual sessions is coordinated with the mode that is currently being focused on in the group sessions. The work in IST supports the GST work and vice versa in a reciprocal relationship. Often patients will have questions related to their individual issues from the group session that can be best answered in the individual sessions. Also more detailed, content-focused work on a specific schema or mode of an individual patient can be done in IST. The ST concept (Individual Schema Therapy 2: Your Schema Therapy Conceptualization (IST-ST2)) of a patient is worked out in IST as well as their specific goals, which are identified and associated clearly with the modes (Individual Schema Therapy 3: My Goals in Schema Therapy (IST-ST3)). The ST conceptualization is the guide for treatment and the first version should be done as soon as possible. It is refined later in the sessions that focus on the Healthy Adult Mode (HAM). The individual session is the place where it is made most clear to patients how the ST work applies to them.

We have outlined 12 individual sessions in this chapter, with 35 possible interventions, from the cognitive, behavioral pattern-breaking, and experiential components of ST. These interventions can be used separately or combined, depending on session length and the pace of you and your patient. Included are notes for the therapist, "tips," sample lecturettes, handouts, exercises, and therapy assignments: a complete package of materials for IST. Each session is described in the text followed by the handout or exercise sheet. All patient materials are available as separate sheets on the wiley.com web site (www.wiley.com/go/farrell) in color and reproduceable. Table 5.1 summarizes these materials and gives their location in the book.

As discussed in Chapter 3, for a manual to truly represent ST it must have the capability for individualization based upon the mode a patient

The Schema Therapy Clinician's Guide, First Edition. Joan M. Farrell, Neele Reiss, and Ida A. Shaw.
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Table 5.1 Patient materials for Individual Schema Therapy sessions

Mode	*Handout*	*Title*	*Page*
Overall	IST-ST1	Schema Therapy Conceptualization Example	268
	IST-ST2	Your Schema Therapy Conceptualization	269
	IST-ST3	My Goals in Schema Therapy	269
	IST-ST4	Example of a Problem Summary in Mode Terms with Treatment Plan	271
Maladaptive Coping Modes	IST-MCM1	Behaviors of Your Maladaptive Coping Modes	273
	IST-MCM2	Behavioral Experiments for the Maladaptive Coping Modes	273
	IST-MCM3	Pros and Cons of My Maladaptive Coping Modes	275
	IST-MCM4	Cognitive Distortions of the Maladaptive Coping Modes	277
	IST-MCM5	Making an Agreement with My Maladaptive Coping Mode	279
Dysfunctional Parent Modes	IST-DyPM1	Historical Role-Play	281
	IST-DyPM2	Weekly Positive Schedule	283
	IST-DyPM3	Instructions for the Identity Circle	284
	IST-DyPM4	Cognitive Distortions of the Demanding Parent Mode	287
	IST-DyPM5	Flashcard for Fighting the Dysfunctional Parent Mode	291
Vulnerable Child Mode	IST-VCM1	New Techniques to Soothe My Sad Vulnerable Child Mode	292
	IST-VCM2	Fears of My Vulnerable Child Mode	294
	IST-VCM3	The Needs of Children	296
	IST-VCM4	The Rights of Children	298
	IST-VCM5	Flashcard for the Vulnerable Child Mode	301
Angry Child Mode	IST-ACM1	Flashcard for the Angry/Impulsive Child Mode	303
	IST-ACM2	Reactions of Others to My Angry Child Mode	304
	IST-ACM3	Needs of the Angry Child Mode	306
	IST-ACM4	The Healthy Need for Attention	308
Happy Child Mode	IST-HCM1	Evoking Your Happy Child Mode	312
	IST-HCM2	Likes of My Happy Child Mode	313
	IST-HCM3	Positive Feedback for the Happy Child Mode	315
Healthy Adult Mode	IST-HAM1	Behavioral Experiments for the Healthy Adult Mode	316
	IST-HAM2	Getting to Know Your Healthy Adult Mode	318
	IST-HAM3	Your Healthy Adult Mode and the Future	319

is in. The new content covered in this program follows a defined sequence, but this does not restrict therapists to dealing *only* with that content or mode as is the case with many skills groups. As in GST, we advise ST beginners to stick to the mode sequence described here and to use one of the interventions provided for the mode of focus. However, you can choose which component of ST to utilize – **cognitive, experiential, or behavioral pattern-breaking**, based upon your patient. More advanced schema therapists have the option of choosing the intervention that best matches the mode the patient is in during the session. This flexibility requires more skill in identifying modes and practice with the main mode interventions. Individualization is always present in limited reparenting, as this approach requires that therapists adjust their response based upon the need that underlies the patient's mode; for example, validation and comfort for the Vulnerable Child Mode's (VCM) need and limit setting or empathic confrontation for the Maladaptive Coping Modes (MCM). Table 2.3 is a helpful reference for matching intervention with need and mode.

5.1 The Schema Therapy Conceptualization and Goals

Schema Therapy conceptualization begins in the ST Education sessions when the patient is first exposed to this treatment model. ST is collaborative, thus we begin talking to the patient early in treatment about how we understand his/her problems in terms of the ST model. An advantage of the model is that the language is user-friendly and patients are provided with an explanation for their psychological problems and symptoms that has face-validity. It is essential to have a shared problem definition and goals for treatment. Although the conceptualization and goals are discussed in both GST and IST, because more history and content are shared in individual sessions, the more elaborated ST conceptualization is largely developed in IST and shared in an abbreviated form in GST during the week of the Healthy Adult Mode (HAM). The "pie chart" mode distribution completed in the last ST Education group is the version developed and discussed in GST sessions (Schema Therapy Education Session 5: Identifying Modes (ST-ED 5)). It is advisable to complete the ST conceptualization by session 3. You work out with your patients which modes are associated with which thoughts, feelings, and behaviors. Individual Schema Therapy 1: Schema Therapy Conceptualization Example (IST-ST1) provides an example conceptualization and additional examples can be found in Arntz and Jacob (2012).



Sample Therapist Script

As you know from the ST Education Group, all people have different versions of schemas and modes. Today I want to work out with you which modes you have and what exactly these modes look like. [You can now ask patients which modes they think they have from the ST Education group and work with their answers to fill in the form in Individual Schema Therapy 3: My Goals in Schema Therapy (IST-ST3). If your patient does not remember, you can follow this sample script to identify them.]

Let's start with the innate child modes, which are VCM, ACM, and Impulsive Child Mode (ICM). They are the modes in which we feel emotional pain or distress. [If the patient still does not remember, give him/her examples of each mode.] *So, tell me about your VCM and I will write it down.* [Do the same for all other child modes.] *Then we have the Dysfunctional Parent Modes (DyPM), which make us suffer.* [If the patient does not remember, give him/her an example of the DyPMs.] *What is the experience of this mode like for you? Is your version punitive or demanding or both?* [You need to make a connection between the modes and related biographical experiences. You can write these connections down on the side of the form next to the circles or rectangles.]

There are two main ways of coping with negative experiences. One way is adaptive and that is the HAM, which I know you have, because you came to therapy. There are also MCMs which helped you to survive when _____ happened (make a connection to biographical experiences), *but now they prevent you from having your needs met adequately. Can you remember any MCM from ST Education group?* [Let your patient give examples; if he/she cannot think of examples, provide some.] *Which MCM are you aware of and how do you react when you are in this mode?* [Let them explain. If you have noticed additional MCMs that you think are relevant, tell the patient what you have noticed. If they disagree about having the mode that you have noticed, tell them that you will both think about it and come back to it later, if it seems necessary. Make it clear to the patient that the ST conceptualization is a "work in progress" and that new modes can always be added and connections clarified throughout treatment.]

One mode that I do not want to forget is the Happy Child Mode (HCM). Can you tell me a little bit about your experience of this mode?

Do we have all the modes written down that you think are important? Do you feel that this conceptualization represents you? [If not, change accordingly.] *Great, because these are the modes that we will work with in the ST program.*

[You also work out the goals of Schema Therapy for each patient and associate them with the modes. You can use the handout IST-ST3 for this part of the session.] *So now that we know which modes you have, let's talk about what you want to change regarding these modes. Let's look at the ST Education group handouts again. As you learned, there are different goals for each mode. Which of the listed goals do you think are most relevant to your modes? Take a look at the difficulties you experience in this mode; what do you think needs to change?* [Be aware that patients tend to set goals too high. Make the goals achievable in the length of your treatment program and identify the steps toward the goals. Remind them that they can continue to work on these goals in the future, but for now it is important to set achievable goals to keep their motivation to work on change up.]

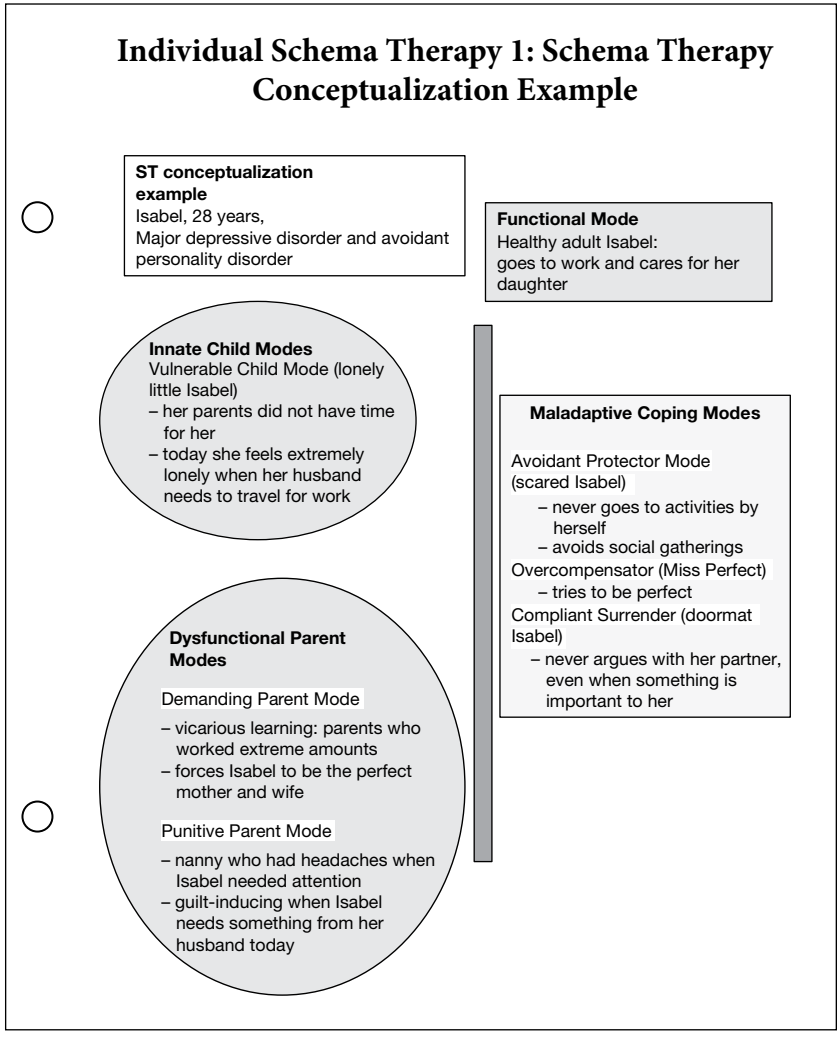
5.2 The Maladaptive Coping Modes (MCM)

The choice of which MCM(s) to focus on is based upon which one is used most and is most problematic. For example, Compliant Surrender can create an unhappy life, but the Overcompensating Mode Bully-Attack could lead to a prison sentence. The latter would be the first focus since it causes the most serious damage.

5.2.1 Schema Therapy behavioral pattern-breaking interventions

a Behaviors of the MCMs (Handout: IST-MCM1)

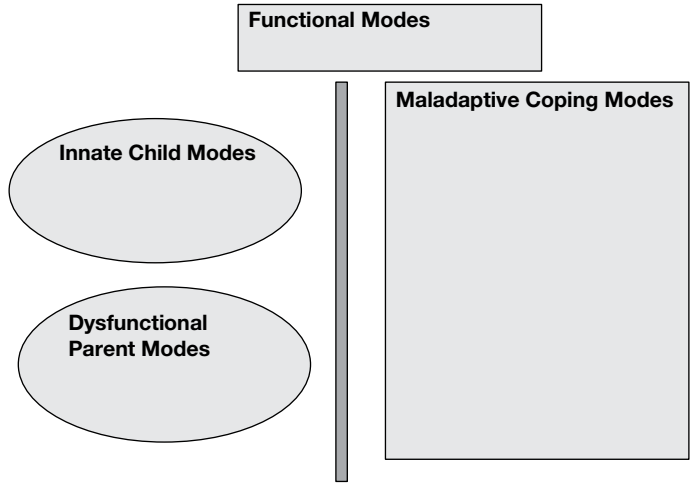
Most patients have more than one MCM. To understand yourself, it is helpful to know which MCM you utilize, the main situations that trigger it, and what your usual behavior in the mode is. We start this exercise by telling patients that most people have different MCMs and remind them of their work in the ST Education group. One exercise to identify MCM behavior is Individual Schema Therapy MCM 1: Behaviors of Your Maladaptive Coping Modes (IST-MCM1). Ask your patient which behaviors he/she has trouble with. Give examples (e.g., getting in fights with people, taking drugs, staring at the wall for hours) and clarify which mode the behaviors fit – avoidant, surrendering, or overcompensating. Focus on excessive behaviors (e.g., playing video games all night long) and deficit



behaviors (e.g., not talking to people, procrastinating). Make it clear that many behaviors become maladaptive only when they occur excessively or not enough. When you have found one or more behaviors that your patient has problems with and that you think are part of an MCM, write them down on the handout or let your patient write them down. Next, try to find a *situation* in which this behavior occurs. The idea is to identify *triggers* for the MCM. Name the MCM with your patient in everyday language. It is important to find a name that has not just negative connotations (e.g., "my Princess Mode" or "Bart Simpson Mode"). Once you have a name for the

Individual Schema Therapy 2: Your Schema Therapy Conceptualization

Make a treatment conceptualization with your therapist. Match the symptoms or problems you experience with modes. Define your goals of treatment. Make the treatment goals reachable. Also connect the goals to specific mode changes.



Individual Schema Therapy 3: My Goals in Schema Therapy



My MCM mode: _____

Difficulties I experience when I am in this mode:

_____

_____

My goal of ST treatment regarding this mode:

_____

_____

My Child mode:_____



Difficulties I experience when I am in this mode:

_____

_____

My goal of ST treatment regarding this mode:

_____

_____

My DyPM mode:_____

Difficulties I experience when I am in this mode:

_____

_____

My goal of ST treatment regarding this mode:

_____

_____

My _____ Mode: (this one can be another MCM, ICM or DyPM or to strengthen the HAM or HCM)

My mode:_____

Difficulties I experience when I am in this mode:

_____

_____

My goal of ST treatment regarding this mode:

_____

MCM, use that name in all therapy sessions as it makes the mode more personal, not just a theoretical construct.

b Behavioral experiments for MCM (Handout: IST-MCM2)

Different situations and people trigger different intensities of the MCM. In this session you will identify those. Begin with the most dominant MCM. Use the group handout ST Education Session 2: Identify Your Mode Experiences I (ST-ED 2 – Section 4.3) to see what trigger situations your patient identified. Determine situations that can elicit MCMs at different intensities. Plan the behavioral experiment situations with your patient. If Mode Awareness Group Session 1 has taken place, you can refer to handout Management Awareness Assignment 1: Awareness of My Maladaptive Coping Mode (MA 1-MCM1 – Section 4.4) for the different components of a mode (thoughts, feelings, physiological reactions, behaviors). The behavioral experiments are an assignment for this session. In the next

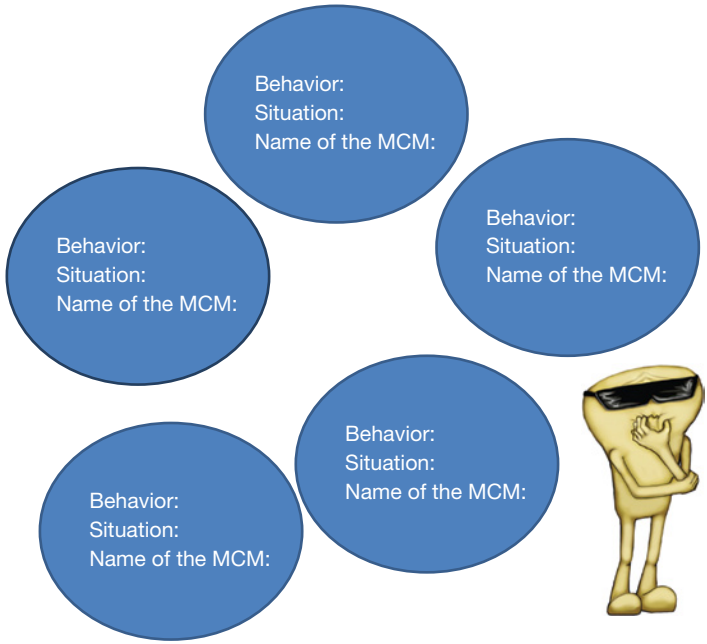
Individual Schema Therapy 4: Example of a Problem Summary in Mode Terms with Treatment Plan

Schema mode	*Schema triggers*	*Your problems/issues related to this mode*	*Do you flip? To which mode?*	*How are you working on this?*
Vulnerable Child Mode	Feeling hurt. Remembering how Mom treated me. Remembering abuse. Being talked to in a loud or mean voice. Feeling abandoned or scared.	Feeling hurt about something in the present brings up a lot of old hurt feelings and my VC cannot tolerate having these feelings.	Yes, sometimes I flip to IC Sometimes I flip to PP Sometimes I flip to DP	1. *Identify need*: to feel cared about. To feel I have stability and safety. 2. *Ask (therapists, group) for help with need*: I could ask for a hug, or for someone to sit with me. 3. *Access your HA for help*. For example, do a circle to access your HA (cortex). 4. My HA could get a soft blanket to wrap up in and my bear to cuddle. I could rock and remember Grandma hugging and rocking me.
Angry or Impulsive Child Mode	Feeling I cannot stand the feeling for a minute more. I need my need met now!	In this mode, I cut myself or swallow, anything I can to end the scary hurt feelings.	Impulsive Child Mode	5. **I need** to ask others for help to stay safe – like not to have anything unsafe near me and not to have objects to swallow.

Schema mode	*Schema triggers*	*Your problems/issues related to this mode*	*Do you flip? To which mode?*	*How are you working on this?*
Punitive or Demanding Parent Mode	This flip gets triggered if I hear my internal parent voice say it is my fault or I am bad.	In this mode, I hurt myself as punishment for feeling, being "weak."	⇣ Punitive Parent Mode	6. **I need** Good Parent protection. 7. I could talk about what I feel with someone who will reassure me that I am good. 8. I could access HAM and use the soothing image we worked on in group or read Good Parent cards.
Maladaptive Coping Mode	This can happen automatically when I get to a high intensity or overload.	In this mode I may self-injure later – to feel *something*, if it gets too scary to feel numb. I can start to feel unreal.	⇣ Detached Protector Mode	9. **I need** to reduce my hurt feelings. 10. I could vent my feelings. 11. I could use healthier detachment like my safe-place or safety image. 12. Awareness that I am getting too distressed is important to stop DP.

Individual Schema Therapy MCM 1: Behaviors of Your Maladaptive Coping Modes

Most people have different Maladaptive Coping Modes (MCM). It is helpful to know what yours are, the situations that trigger them, and how you react when you are in each MCM.



The MCM I have most often is: _____

My most dangerous MCM is: _____

Individual Schema Therapy MCM 2: Behavioral Experiments for the Maladaptive Coping Modes

Different situations and different people trigger your MCMs, but not all of them trigger them at the same intensity. Let's find out what your differences in intensity are.

Example: My Avoidant Protector says that peers are really dangerous and I should avoid them.

My Avoidant Protector says that because I was bullied by other kids in school I started avoiding other people.



A behavioral experiment I worked out with my therapist is:

1. Example: Talk to my neighbor for 5 minutes and afterward rate the intensity of my Avoidant Protector.

_____

_____

0 = no Avoidant Protector — 10 = only Avoidant Protector

2. Example: Talk to another person in the clinic waiting room for 5 minutes and rate afterward how strong the AP was. _____

0 = no Avoidant Protector — 10 = only Avoidant Protector

3. Example: Talk to a group of people waiting for my gym class.

_____

0 = no Avoidant Protector — 10 = only Avoidant Protector

What did you learn from these behavioral experiments?

_____

_____

_____

session, discuss the differences in MCM intensity that were observed and discuss how much control the patient thinks he/she has over that MCM. Discuss ways to have control over MCMs. See handout Individual Schema Therapy MCM 2: Behavioral Experiments for the Maladaptive Coping Modes (IST-MCM2).

5.2.2 Schema Therapy cognitive interventions

a Pros and Cons of MCM (Handout: IST-MCM3)

With Individual Schema Therapy MCM 3: Pros and Cons of My Maladaptive Coping Modes (IST-MCM3) you can collect the Pros and Cons of an MCM. It is important to start with the Pro side. When you look at patients' biographies, why they developed a particular MCM is usually understandable. We collect the biographical experiences in which the MCM was helpful (or even was necessary for their survival) first. Then we look at the patient's current life and evaluate whether the MCM has been helpful in the past three months. Keep in mind that if patients' life circumstances make having a healthy life difficult (e.g., if patients still live in their abusive families of origin, work in prostitution, or are in a criminal milieu), it may not be a good choice to change their MCMs for dealing with the survival aspects of their environment now. You can suggest situations in which the MCM was helpful, if you know any. Then work on the disadvantages or Cons of the MCM. Have the patient list all of the Pros and Cons identified in the table at the bottom of the handout.

Individual Schema Therapy MCM 3: Pros and Cons of My Maladaptive Coping Modes

(Advantages or benefits versus disadvantages or problems)

Your MCMs have helped you to survive difficult and painful situations in your past, particularly in childhood. This is one reason why they have so much power over you now. However, they may not be working to get your needs met in your present life. Let's see …

List the past situations in which your MCM was helpful:

_____
_____
_____
_____
_____
_____
_____

List the situations in your present life over the last 3 months where your MCM was helpful for you:

_____
_____
_____
_____
_____
_____
_____

Now let's put it together and compare the arguments for and against keeping your MCM at the same intensity in your current life:

Pro MCM (advantages)	*Con MCM (disadvantages)*
	

b Cognitive distortions of MCM and cognitive antidotes from the HAM (Handout: IST-MCM4)

Handout Individual Schema Therapy MCM 4: Cognitive Distortions of the Maladaptive Coping Modes (IST-MCM4) looks at the cognitive side of an MCM by identifying the cognitive distortions that maintain it. Go over the example. Then ask what your patient's MCM thinks about him/her ("You cannot let other people see too much of you, or they will find out that you are defective"), about other people ("Other people are mostly mean and will try to humiliate you. Stay away from them"), and about relationships ("Just tell them they are right, so they don't leave you"). The second part of the handout looks at cognitive "antidotes" or reality checks that the HAM can remind you of. Work with your patient to develop his/her set of antidotes to fight the MCM distortions. This handout can be kept in the therapy binder as a reference.

Individual Schema Therapy MCM 4: Cognitive Distortions of the Maladaptive Coping Modes

When you are in your MCM you see the world through a specific filter. This filter is distorted by your schemas. Let's find out what the cognitive distortions of your MCM are:

Example: "If you trust people, they will only hurt you." Is that one of your beliefs? What are some others from the MCM?

1. _____
2. _____
3. _____
4. _____
5. _____



Cognitive Antidotes from Healthy Adult Mode

Let's see if your Healthy Adult Mode can find "antidotes" to the cognitive distortions of your MCM:

Examples: "People *can* hurt you, if you trust them, but *most people will not* hurt you *on purpose*. As an adult you can deal with painful experiences without being destroyed." "You can only have relationships if you trust *some* people and you want to have relationships; that is important to you."

1. _____
2. _____
3. _____
4. _____
5. _____



5.2.3 Schema Therapy experiential interventions

a Empathic confrontation

When your patient is in an MCM, point this out and connect it to biographical experiences when this MCM was helpful. Acknowledge the protective goal of the MCM in the past (e.g., to protect the patient from further pain, to not lose relationships with others), but point out that it does not accomplish this goal in the present. These steps empathically confront the patient with the need for change. Empathic confrontation in ST requires that you have enough connection with patients that they can have some amount of acceptance that you have their best interests at heart and are not just being critical. We *reinforce the connection* by saying: "I am not saying this to be critical. I am saying it because I am concerned that your old protective behavior will not get your needs met today." Then we *point out the problem with their MCM behavior* in terms of *not getting their need met*. For example, "I understand that because you were bullied as a child your Avoidant Protector takes over when you meet new people and you get away as soon as possible, but I am concerned that that strategy keeps you from ever finding friends who would be kind and accepting." Then we *offer a correction*, a behavior that could meet their need. "You could decide to collect information about whether a new person is safe before letting the MCM take over and protect you in its way. That way, your need for companionship with a safe person has a chance of being met. The other way you will stay alone." We offer help with the correction behavior. "We can work on how you could decide whether a new person is safe and even role-play asking questions in our session."

> So the "**formula" or steps for empathic confrontation** are:
>
> 1. Reinforce your connection with the patient.
> 2. Name the maladaptive behavior.
> 3. Point out that it does not meet get their needs met.
> 4. Offer a correction – a behavior that will get their needs met.
> 5. Offer assistance in learning to make the correction.

Then use handout Individual Schema Therapy MCM 3: Pros and Cons of My Maladaptive Coping Modes (IST-MCM3). Go over it with the patient and let them decide whether to work on decreasing the frequency or intensity of the MCM.

b Mode dialogue for the MCM (Handout: IST-MCM5)
This dialogue uses handout Individual Schema Therapy MCM 5: Making an Agreement with My Maladaptive Coping Mode (IST-MCM5).

1. Have two extra chairs ready, in addition to your usual therapy chairs. Identify a situation in which your patient was in an MCM.
2. Define one chair for the MCM and have your patient take that chair as his/her MCM and say whatever the MCM needs to say.
3. Define another chair for the HAM. If it is possible for your patient to be in the HAM, have him/her take that chair and say what the HAM has to say to the MCM. If your patient does not know what to say as the HAM, coach him/her with what the HAM would say. If it is not possible for your patient to take the HAM chair at all, have him/her stay in his/her usual therapy seat. Ask your patient if you can take the HAM chair and play his/her HAM. Take that chair and speak as the HAM to the MCM. Then ask your patient if the MCM is saying anything in response. If yes, have the patient say it and then you answer the MCM.
4. Continue the dialogue briefly to negotiate an agreement or deal with the MCM that allows the HAM to take more control over the patient's life and agrees that the MCM needs to be less intense. You can use the handout for that step.
5. Go back to the therapy chairs and discuss how this agreement can transfer to the patient's daily life.

Individual Schema Therapy MCM 5: Making an Agreement with My Maladaptive Coping Mode

I want my Healthy Adult Mode to take more control in therapy, because

_____
_____
_____
_____

My Healthy Adult Mode can take more control in therapy in the following way:

_____
_____
_____
_____

I want my Healthy Adult Mode to take more control in my life, because

○ _____
_____
_____
_____

My Healthy Adult Mode can take more control in my life in the following way:

_____
_____
_____
_____



5.3 Dysfunctional Parent Modes (DyPMs)

5.3.1 Schema Therapy behavioral pattern-breaking interventions

a The historical role-play (Handout: IST-DyPM1)

In historical role-plays various perspectives in a situation are examined, for example the perspective of the child and the perspective of the other person (for example, the caretaker). This is done in a situation where alternative interpretations which could lead to a change in emotions and cognitions are possible. Do not use this technique for trauma or abuse situations. Although this intervention is behavioral, the aim is not behavioral rehearsal, but a change at the schema level in the meaning of the event. Use handout Individual Schema Therapy DyPM 1: Historical Role-Play (IST-DyPM1).

Historical Role-Play Phases

1. In the first phase of a historical role-play, the original situation is re-played with the patient taking the role of the child, the therapist taking the role of the other. After the role-play the therapist can assess what assumptions the patient is making about what the other person is thinking about him/her. Have your patient write these assumptions down on the handout form.
2. Then, in the second phase, the roles are switched, with the patient taking the other person's role and the therapist taking the patient's role. This allows the patient to experience the situation from a different perspective. After this second role-play, asses the assumptions again, this time from the perspective of the other person. Have your patient write his/her assumptions down.
3. Discuss options for a new behavior to try in the situation. Coach as needed to shape your patient in the direction of a functional behavior.
4. In the third phase, your patient takes the child role again and tries out the new behavior, and the therapist plays the parent/other role. Again, the assumptions from the perspective of each role are identified.
5. Examine together all of the different assumptions. The goal of the exercise is for your patient to learn that different perspectives are possible, that his/her first assumptions may not always be correct, and so forth, and how our assumptions affect our behavior and the result of the interaction.

Individual Schema Therapy DyPM 1: Historical Role-Play

First Play: The Original Childhood Situation

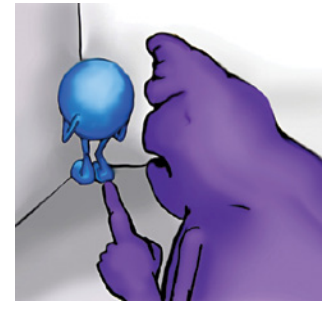
○ What I assume the other person thinks:

_____

_____

_____

_____



What I think:

_____

_____

Second Play: When We Switched Roles

What else could the other person think (alternatives):

_____

_____

What else I could think (alternative):

_____

_____

Third Play: Trying Out My New Behavior

Look at all of the above conclusions.

From this experience, what do you need to take into consideration in the future?

_____

_____

b Weekly positive schedule (Handout: IST-DyPM2)

A behavioral strategy to work on banishing the DyPMs is to engage in positive, fulfilling activities. Handout Individual Schema Therapy DyPM 2: Weekly Positive Schedule (IST-DyPM2) is used during the session to plan positive activities. Go through the example and then brainstorm other positive activities and the exact times when those activities can be done during the following week. Make sure that your patient allows enough time for the activities to avoid pressure. As an assignment, ask your patient to fill out the last column to assess how he/she felt after engaging in the activity. Later on, if the patient did not feel good after the activity, you can assess with him/her which modes interfered with positive feelings and what strategies the patient could use in the future to reduce mode interference. The handouts from the Mode Management group can be referred to or used for this purpose.

5.3.2 Schema Therapy cognitive interventions (Handout: IST-DyPM3)

a Instructions for the "identity circle"

Frequently when we work on reducing DyPMs, over time we notice that patients feel that their absence leaves a "hole" or emptiness. It is as if their old decrepit home with its faulty foundation finally fell down, but now

Individual Schema Therapy DyPM 2: Weekly Positive Schedule



One way to work against your Dysfunctional Parent Modes is to engage in positive activities – ones that you enjoy or are helpful to you or positive for other people.

Day	*My positive activity*	*Time plan*	*How I felt after my positive activity*
Example	I want to make dinner for me and my friends.	Tonight at 8 pm. I can start cooking at 7 pm.	I felt good when my friends told me they really liked the dinner and I was able to enjoy eating some of it also.
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			
Saturday			
Sunday			

nothing is there and something new must be constructed to replace it. Of course, the healthy replacement that we suggest is a stronger HAM identity. Handout Individual Schema Therapy DyPM 3: Instructions for the Identity Circle (IST-DyPM3) is used for this purpose.

1. The first task is to identify Punitive (PPM) or Demanding Parent Mode (DePM) statements together with your patient. He/she might already be aware of some of these from his/her GST sessions. Instruct him/her to write all the statements down in the DyPM Statements sections of the circle.
2. Then record basic information that the patient has about him/herself in the fact section.
3. In the new positive facts section, ask him/her to write down new positive things he/she has learned during ST. These can be from peers, therapists, other members of the treatment team, and so forth.
4. Then identify "leftovers" – these are defined as past situations in which the patient had problems; for example, by not making a good decision, by having acted badly or failed in some way. Record the effects of these leftovers on your view of yourself, or your identity. It is important for the therapist to respond to these in a personal way to demonstrate that you will not reject or abandon your patient for having made mistakes. Forgiveness is one effective antidote for the DyPMs.
5. Go over the "antidotes" with the patient and convert them to flashcards for repetition.

Individual Schema Therapy DyPM 3: Instructions for the Identity Circle

In Schema Therapy we want to help you develop your own stable identity, including a Healthy Adult Mode who can take adequate responsibility for him/herself and meet your needs.

Discuss what the following kinds of information have contributed to your identity.

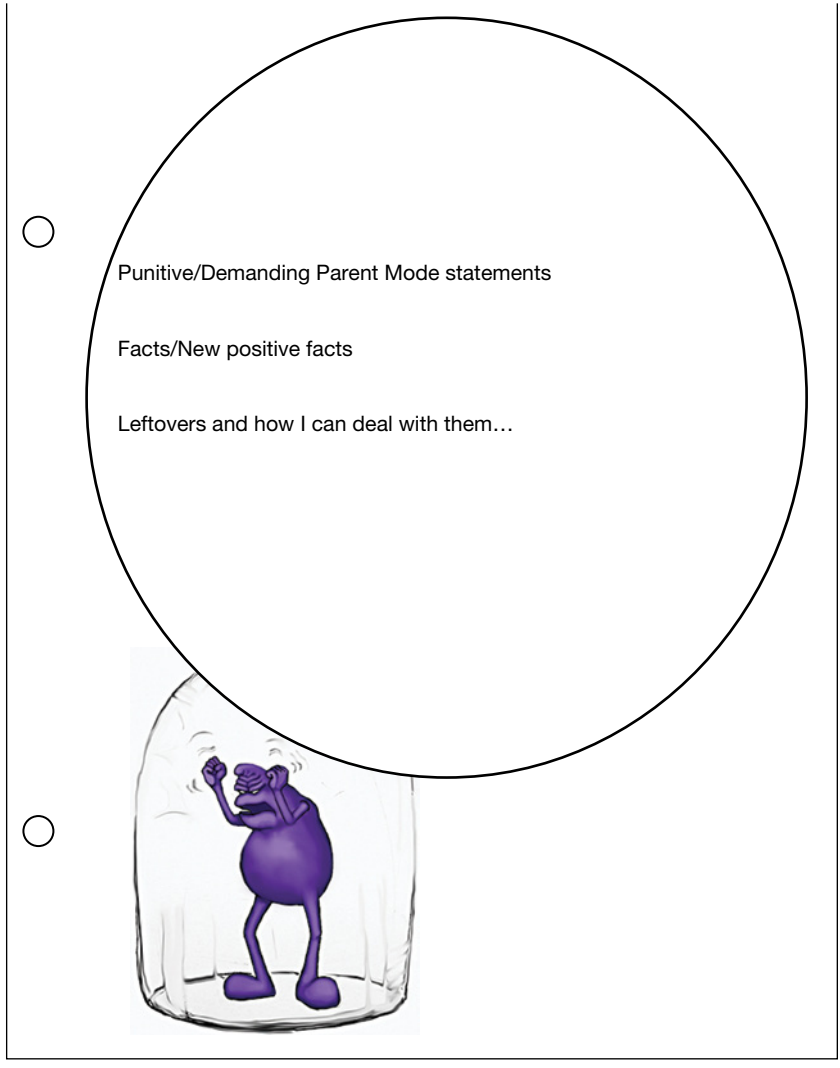
1. **Punitive/Demanding Parent Mode statements**, for example, "You are a loser" or "You never get anything right," "You must do more," and so forth. What are your PPM or DePM messages?

2. **Facts** that give basic information about you. For example, what are your successes and accomplishments? What have you done in your life up to now?
3. **New positive facts** – Here is the place to put in the positive feedback you get from peers, therapists, staff, etc. These are "facts" about you that you can work to accept and eventually will come to replace distorted facts from your childhood. Growing up we accept the "facts" of our parents and other people important to us, as it is all we know. Why not reconsider what you accepted as "facts" when you were a kid? Back then you knew no better and you did not have healthy, positive adults to provide more accurate feedback. Why not work to take in facts about yourself from less biased people – like your therapists and peers? Remember that you have decided to believe reliable people and not listen to your Maladaptive Coping Modes.
4. "**Leftovers**" – All of us have made mistakes and done things that we are not proud of. You may still struggle with some of the "leftovers," conclusions about yourself based upon mistakes. Write down what these leftovers are for you. We will look at them together and what you may need to do to have closure around them.

Antidotes to the Punitive and Demanding Parent Modes include:

- identifying the foundations of a negative belief and re-evaluating and correcting any distortions in it;
- learning to love and accept yourself by making peace with past mistakes and having healthy and reasonable expectations for yourself;
- taking in the validation and acceptance that are available now in your environment, particularly in the ST Program, and protecting yourself from rejecting or negative people.





b Cognitive distortions of the Demanding Parent Mode (Handout: IST-DyPM4)

The Demanding Parent Mode sets up a lot of rules for life, or commandments. Trying to live by these rules causes severe pressure and unhappiness. In following them, patients may have put aside and even forgotten about their own goals and dreams. Using Individual Schema Therapy DyPM 4: Cognitive Distortions of the Demanding Parent Mode (IST-DyPM4),

identify the 10 most important "commandments" of their Demanding Parent Mode from examples of that mode's messages. Identify the distortions and the issues of impossible standards in the DePM's rules. Then help your patients establish their own Healthy Adult standards. A necessary step is to help them find antidotes for each of the Demanding Parent Mode's statements and write these antidotes down. After doing this, discuss their reactions to, and feelings about, their new "guidelines" to replace the "commandments."

Individual Schema Therapy DyPM 4: Cognitive Distortions of the Demanding Parent Mode



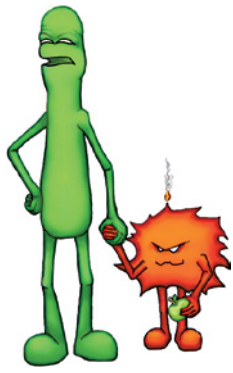
The Demanding Parent Mode generally has a lot to say about how you should live your life. Examples are:

"You must always put everyone else's need before your own."
"You must look perfect."
"You can never make any mistakes."

Let's look at all the **commandments** your Demanding Parent Mode has for you:

1. *Everything you do must be perfect.*
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

You don't have to live by the rules of your Demanding Parent Mode. Now write down the antidotes or guidelines that your Healthy Adult Mode has:



1. *Example: Do your best, it is good enough.*
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

How do you feel now?

5.3.3 Schema Therapy experiential interventions

a Imagery rescripting exercise for the DyPMs

Imagery rescripting can be described in **steps**. For the DyPM, the patient comes to the session in that mode or talks about a situation in which he/she was in that mode. The therapist leads the imagery work by asking the patient to get into a comfortable position and close his/her eyes, or look down, to do an imagery rescripting exercise.

1. In step 1 the *image is activated*. The therapist asks the patient to access the current emotion (or the emotion of a situation in which he/she was in the Vulnerable Child Mode (VCM)).
2. The current emotion is then used as an *affect bridge* back to a childhood image. Once the patient is in the childhood image, help the patient make the image emotionally salient. The language is therefore kept in the present tense and the therapist asks the patient to describe any thoughts, feelings, needs, and physical sensations he/she is aware of. *Do not let the patient describe a trauma or a painful experience fully*. It is not necessary or desirable to re-experience this, rather to stop and rescript before the image gets to that point ("before anything bad happens"). In an imagery rescripting exercise for the DPM, generally a negative attachment figure will come into the picture.

3. *Intervene at once*, just as the traumatizing event starts (for example: "I can hear my stepfather coming up the stairs," or "I can see my teacher making that face again, when she is going to say how stupid I am," or "My mom says she has a headache because of my bad behavior"). Ask your patient if you can enter the image. Talk to the attachment figure. Make it clear that his/her behavior is not acceptable and clarify what the child needs and deserves to get. If the attachment figure argues, rebut his/her statements once, then stop them. If not, fulfill the need of the child (e.g., take him/her out of the scene, play with the child) without the attachment figure. Ask the child what else he/she needs and in imagery fulfill the needs of the child.

The roles of the therapist and patient in rescripting change in **steps**:

1. The first few times we do imagery work, we go into the image to be the rescripter as the "Good Parent."
2. The next step is to take the "Good Parent" part of the patient with you; the patient hears you speak first, then he/she practices speaking from his/her "Good Parent" while you coach as needed.
3. The patient's HAM goes into the image and you go along as the coach. At this point the patient has internalized the "Good Parent," which is part of the HAM.
4. After a strong HAM has developed, the patient can go into the image on his/her own.

An important difference in the ST approach to rescripting is that we do not assume that patients have a well-developed HAM to call upon. We assess the strength of their HAM and provide them with a "Good Parent" model to internalize in the development of their HAM. We see this as filling in one of the deficits in early emotional learning.

Be aware that patients with severe personality disorders may not be able to name their need. In that case, propose creative solutions to meet what you assume the need to be. End the imagery when the needs of the child are met.

We follow imagery rescripting with discussion of the experience. It is important to identify the experiences that were helpful in the imagery and whether the need from the imagery is still present in a particular mode. Find ways to transfer the rescripted "Good Parent" behaviors to the patient's current life (e.g., "So, if you are in the PPM today, you can argue with the

PPM's negative messages from your 'Good Parent' like you did in the imagery. What do you think? How could your HAM stop the PPM today?"). It can be very helpful and can facilitate internalization of you as "Good Parent" to give your patient a recording of the imagery rescripting exercise to listen to again as homework. Even without recordings, our patients often tell us that they are able to hear our voices again when they practice the rescripted image.

b Mode dialogue for DyPMs

1. Have three extra chairs ready in addition to your usual therapy chairs – for the DyPM, the HAM, and the VCM. Use this intervention either when your patient is in the PPM or the DePM in the session or when they tell you about a situation when they have been in one of those modes.
2. Set up a dialogue, placing one of the modes in each chair. Make sure that the VCM chair is not physically next to the DyPM. If possible, give the DyPM an uncomfortable chair.
3. Have your patient take the DyPM chair first. Ask him/her to say everything that the DyPM has to say. Be aware of the tone and if the patient uses "I" or "you." If the patient's voice is too soft, ask if that is how the DyPM usually sounds. Usually the patient will say that it is much louder and harsher. Tell the patient to speak in the voice of the DyPM.
4. After everything has been said by the DyPM, have your patient switch to the VCM chair and ask how his/her "little child" feels when the DyPM speaks to him/her like that. Underline the feeling the VCM has in this situation.
5. If possible, ask your patient to switch to the HAM chair. If patients don't feel able to do this yet, have them observe you take Healthy Adult chair. Use this as an opportunity to shape your patients' behavior:
   a. First, let them watch from their therapy seat while you play HAM.
   b. Next, let them experience being in the VC chair with you as HAM.
   c. Then let them sit in the HAM chair while you speak for their HAM.
   d. Let them speak from the HAM chair with you coaching.
   e. Finally, have them speak from the HAM chair.
6. The role of the HAM in this dialogue is to attend to the VCM's current needs (e.g., "I am here for you and I will not let this happen"). The HAM talks to the DyPM, telling the DyPM that his/her behavior doesn't help and therefore he/she needs to be quiet. Do not start a discussion. Just make the DyPM stop talking. If the parent mode will not be quiet, throw him/her (and symbolically his/her chair) out of the room. It is critical for the therapist to be stronger than the DyPM and demonstrate that the DyPM can be banished.

7. Go back to your therapy chairs and discuss the experience. Work out how the patient can implement the newly learned behavior in his/her daily life. You can use the flashcard Individual Schema Therapy DYPM 5: Flashcard for Fighting the Dysfunctional Parent Mode (IST-DyPM5) for that.

Individual Schema Therapy DyPM 5: Flashcard for Fighting the Dysfunctional Parent Mode

I am in my _____ Parent Mode now because (fill in how you identify your DyPM).

Example: PPM – because I am hearing the message that:



○ "*You are a loser and always will be.*"
_____
_____
_____
_____

I really need
The message to stop.
_____
_____
_____
_____



○ My Healthy Adult Mode can help me by
Shutting up the PPM or throwing it out the door.
_____
_____
_____
_____

5.4 The Vulnerable Child Mode

5.4.1 Schema Therapy behavioral pattern-breaking interventions

a New techniques to soothe my sad VCM (Handout: IST-VCM1)
Bring different objects such as teddy bears, books, postcards, fleece squares, a shawl, and so forth to the session. Explore whether these things (or others if necessary) appeal to your patient to function as transitional objects (refer to Section 4.6.2 for a script explaining transitional objects). Talk to your patient about what his/her VCM likes and have him/her record them using handout Individual Schema Therapy VCM 1: New Techniques to Soothe My Sad Vulnerable Child Mode (IST-VCM1). Also try things like warm drinks, cookies, and so forth as soothing activities. Identify the activities that your patient finds soothing and have him/her record those as well on the handout. This is another handout for the patient to keep as a reference for the VCM.

Individual Schema Therapy VCM 1: New Techniques to Soothe My Sad Vulnerable Child Mode

My vulnerable child likes:

1. **People and pets**

_____
_____
_____
_____
_____

2. **Things**
   a. Teddies or other cuddly objects

_____
_____
_____

   b. Books

_____
_____
_____

   c. Postcards

_____
_____
_____

d. Drinks (e.g., tea, hot chocolate) or food

_____

_____

_____

3. **Activities**

_____

_____

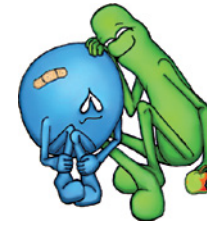
_____

_____

_____

_____

_____



b The fears of my VCM (Handout: IST-VCM2)

With this exercise you can explore the connections between the VCM and other modes. First, using handout Individual Schema Therapy VCM 2: Fears of My Vulnerable Child Mode (IST-VCM2), try to assess with your patient what his/her VCM is afraid of. Examples may be exams, visiting doctors, conflicts with family members, loneliness, and many other things. After identifying four of the VCM's fears, ask your patient how his/her DyPM reacts to his/her VCM's fears. Then ask about how his/her MCMs react to his/her VCM's fears. Identify what the needs underneath the fears are. Discuss whether either the DyPM or the MCMs actually meet the needs of the child. Do not simply accept a yes or no answer; discuss why or why not. Then ask your patient if his/her HAM (or his/her "Good Parent" (GP) if this aspect of his/her HAM is better accepted by him/her*) can meet the VCM's needs and if so, how? Do a *short imagery exercise* that you script in which your patient imagines the HAM (or GP) meeting the VCM's needs. We discuss the GP as a part of the HAM and we find that patients often have access to the GP for others but do not use it for their own needs. Since many are more able then to access the GP than their HAM, we use this concept as a transition to patients accepting and developing their HAM. Many patients find the "Good Parent" concept less threatening as they fear that when they have HAM therapy the therapists' support will end. [*So in exercises like this we use whichever HAM or GP the individual is most comfortable with.] Find out how the patient feels in the imagery exercise. At the end of the session, have your patient create an image of that experience. Have him/her recall the image as an experiential antidote to DyPM messages.

Individual Schema Therapy VCM 2: Fears of My Vulnerable Child Mode

My VCM is scared of:

1. _____
2. _____
3. _____
4. _____

◯ My Dysfunctional Parent Modes respond to my Vulnerable Child Mode by saying:

_____
_____
_____

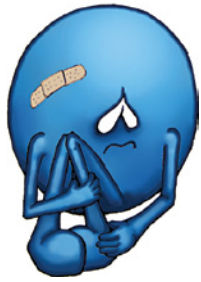
My Maladaptive Coping Modes respond in the following way:

_____
_____

The need of my VCM is: _____
_____

My Dysfunctional Parent Mode's reaction meets the need of my VCM:
O Yes O No

My Maladaptive Coping Mode's reaction meets the need of my VCM:
O Yes O No



◯ Can your Healthy Adult Mode meet the need of your VCM?

_____
_____
_____

What my VCM really needs is_____
My Healthy Adult Mode can fulfill the need of my VCM better by

_____
_____
_____
_____

Imagine your Healthy Adult Mode meeting your VCM's needs. How does that feel?

_____

_____

_____



5.4.2 Schema Therapy cognitive interventions

a The needs of children (Handout: IST-VCM3)

Refer back to the ST Education sessions and ask your patient if he/she remembers talking about core childhood needs and how these needs are related to schemas. If your patient does not remember, explain that all children have core childhood needs and these needs must be met for a child to develop normally into a healthy person. Schemas and modes develop when core childhood needs are not met adequately. This is why we talk to patients about their childhood and how their core needs were met. For the needs that are still present, it is important to find out if, and how, the patient tries to meet them now. Using Individual Schema Therapy VCM 3: The Needs of Children (IST-VCM3), go through the core childhood needs individually with your patient and have him/her write down what his/her childhood and current experiences with needs are. At the end, try to summarize for patients which needs are still important and how they are met. Then clarify that you will try to help them find additional ways to meet their needs adequately, whether they are VCM or adult needs, in one of the following sessions.

Individual Schema Therapy VCM 3: The Needs of Children



All children have core needs. These needs are extremely important and meeting these needs is necessary for healthy development. When a person's core childhood needs are not met, schemas and modes develop. Look at the following list of core childhood needs. How were these needs met in your childhood? For the needs that still exist, how do you try to meet them now?

1. Safety and attachment, predictability and love

Childhood experience with this need:

_____
_____
_____
_____

How I try to meet this need now:

_____
_____
_____
_____

2. Autonomy, competence, identity development

Childhood experience with this need:

_____
_____
_____
_____

How I try to meet this need now:

_____
_____
_____
_____

3. Freedom to express your own feelings and needs



Childhood experience with this need:

_____
_____
_____

How I try to meet this need now:

_____
_____
_____
_____

4. Freedom to play and be creative

Childhood experience with this need:

_____
_____
_____
_____

How I try to meet this need now:

_____
_____
_____
_____

5. Realistic limits and self-control

Childhood experience with this need:

_____
_____
_____
_____

How I try to meet this need now:

_____
_____
_____
_____

b The rights of children (Handout: IST-VCM4)

An important part of ST Education is accurate information about the accepted rights of all children. We say to patients: "Different people have different thoughts on what children's rights are and should be, so I would like to hear what you think children's rights are." Using Individual Schema Therapy VCM 4: The Rights of Children (IST-VCM4), we write their answers down, then discuss and clarify them. A patient might say, for example, that children have the right to live in an appropriate home. Then you could ask what an example of an appropriate home would be. The patient might say that it could be a house where the child has a room shared with siblings, but that it is always warm enough and that there is enough

food for the child. Print out the United Nations Declaration of the Rights of the Child and go over those rights with your patients (http://www.un.org/cyberschoolbus/humanrights/resources/child.asp). Ask if they see any rights that they did not know children had. Patients are often surprised at this internationally developed list of child rights. Discuss whether these rights were respected in their childhood. Let them give examples of times when their rights were not respected and what they learned from these situations. Ask them why this might be important. If they do not know, explain to them that your rights not being respected can have an influence on the development of schemas and modes. You can then connect the information about the way their rights were treated to their current schemas and modes. Be aware that this session can be very emotional for patients, especially if they have been traumatized or neglected. It is crucial that you tell them that while you cannot change their past, you can help them change their future by teaching them how to respect their rights and meet their needs. Patients may be very sad about the loss of their childhood and we acknowledge their sadness and loss. We tell them that some of the healing that the VCM needs comes from grieving what they did not get in childhood and that you will be there to support them in the process.

Individual Schema Therapy VCM 4: The Rights of Children

What do you think the rights of children are? Let's list some examples together.

1. _____
2. _____
3. _____
4. _____

5. _____
_____
_____

6. _____
_____
_____

Now, let's look at the United Nations Declaration of the Rights of the Child. Are there any rights listed that you did not know children have?

_____
_____
_____

Were these rights respected in your childhood?

_____
_____
_____



What effect do you think the way your rights were respected or not had on you?

_____
_____
_____

5.4.3 Schema Therapy experiential interventions

a Imagery rescripting exercise for the VCM

The steps of imagery rescripting for the VCM are similar to those described for the DyPM. The patient either comes to the session in the VCM or talks about a situation in which he/she was in that mode. The therapist leads the imagery work by asking the patient to get into a comfortable position and close his/her eyes, or look down, to do an imagery rescripting exercise.

1. In step 1 the *image is activated*. The therapist asks the patient to access the current emotion (or the emotion of a situation in which he/she was in the Vulnerable Child Mode (VCM)).
2. The current emotion is then used as an *affect bridge* back to a childhood image. Once the patient is in the childhood image, help the patient make the image emotionally salient. The

language is therefore kept in the present tense and the therapist asks the patient to describe any thoughts, feelings, needs, and physical sensations he/she is aware of. *Do not let the patient describe a trauma or a painful experience fully*. It is not necessary or desirable to re-experience this, rather to stop and rescript before the image gets to that point ("before anything bad happens"). *Intervene at once*, just as the traumatizing event starts (for example: "I can hear my stepfather coming up the stairs," or "I can see my teacher making that face again, when she is going to say how stupid I am," or "my mom says she has a headache because of my bad behavior").

3. Ask your patient if you can enter the image, and enter it accordingly. Fulfill the need of the child (e.g., prevent abuse, restore safety). Ask if the child has further needs. Fulfill the needs of the child.
4. Be aware that, for patients with severe personality disorders, patients may not always be able to name their need. It is OK for the therapist to propose creative solutions to meet a suspected need. End the imagery when the needs of the child are met.
5. Come back to the therapy session with your patient and discuss the experience. It is important to focus on the experiences that were helpful in the imagery. If possible, give your patient a record of the imagery exercise to listen to again as homework.
6. Work out with your patient if the need in the imagery is still present from time to time now, when the patient is in a certain mode. Help your patient to find out if the experience that was created in the imagery rescripting can be transferred to his/her current life ("So, if you are in VCM today, maybe the same thing would help you today? What do you think? How could the need of your VCM be met today?"). If he/she has a strong enough HAM, you can suggest that he/she access that mode for the rescripted image as a way to soothe the VCM.

b Mode dialogue for VCM

Mode dialogues are another experiential or emotion-focused way to approach meeting the needs present in the VCM. The steps are similar to those for the DyPM.

1. Have two therapy chairs and three extra chairs ready (for HAM, for VCM, and for another mode, in case another mode comes up). Either your patient is in VCM in the session or he/she tells you about a situation when he/she was in his/her VCM. Ask your patient to do a mode dialogue for this situation. Name the chairs. Make sure that VCM is not sitting next to the DyPM.
2. Let your patient take the Vulnerable Child chair first. Ask the patient to say everything that the VCM has to say. Make sure that the patient expresses the feelings and possibly the needs of the VCM.
3. If possible, ask your patient to switch to the Healthy Adult chair. If patients cannot switch to the Healthy Adult Chair yet, let them watch you take the Healthy Adult chair. Follow the shaping procedure previously described (p. 225).
4. The HAM attends to the VCM needs now ("I am here for you and I will not let this happen"). HAM needs to validate the feelings of the VCM and, at the same time, tell him/her that HAM will manage the situation ("… but I will take care of this. You are safe"). Let HAM tell the VCM what he/she is going to do to take care of the situation. Fulfill the needs of the child until the child feels soothed.
5. Go back to the therapy chairs. Ask your patient how that felt. Work out with your patient how he/she can implement the newly learned behavior in daily life. ("So, if you are in VCM today, maybe the same thing would help you today? What do you think? How could the need of the Vulnerable Child be met today?") (Use Individual Schema Therapy VCM 5: Flashcard for the Vulnerable Child Mode (IST-VCM5).)

The flashcard form for the VCM can be used with either the rescripting or the mode dialogue.

Individual Schema Therapy VCM 5: Flashcard for the Vulnerable Child Mode

○ I am in my VCM now, because *(Example: I am aware of intense fear because my therapist will be on vacation next week – the fear seems too big)*

_____

_____

_____

I really need *(Example: some reassurance that she will come back, maybe like keeping some small object from her office while she is away)*

○ _____
_____
_____

My Healthy Adult Mode can take good care of my VCM by *(Example: asking my therapist if I can have one of her cards with the next appointment on it and keep the shell on her desk until she is back)*

_____
_____
_____



○

5.5 The Angry or Impulsive Child Mode (ACM, ICM)

Keep in mind that most behavioral and cognitive interventions only work when the patient is not fully in ACM. As long as the patient has not vented the anger, there will be limited access to cognition. Our general advice is to use an exercise to vent anger first, before attempting any other ACM exercise.

5.5.1 Schema Therapy behavioral pattern-breaking interventions

a Role-play ACM (Handout: IST-ACM1)

No handouts are needed for a role-play, but flashcards are used as reminders and to facilitate generalization outside of therapy sessions. You can use any situation that your patient experienced where they reacted in the ACM.

Role-play the situation with you playing the other person.

1. First the patient needs to focus on validating whatever he/she feels, by accessing the HAM, who can say to the patient "It is OK to feel angry. This situation is a big deal to you because of similar situations that happened a lot in your childhood that ended badly for you."
2. The HAM can then do a version of empathic confrontation: "Yet, you are not getting your need met by behaving the way you are right now. You need a different way of behaving."
3. You can then work out different ways of behaving with your patient and try out the different ways. You may want to let your patient switch into the role of the other person, too, when trying to find out if the new way of behaving can more adequately meet the needs present in the situation. You can use Individual Schema Therapy ACM 1: Flashcard for the Angry/Impulsive Child Mode (IST-ACM1) to strengthen these new behaviors.

Individual Schema Therapy ACM 1: Flashcard for the Angry/Impulsive Child Mode

○ I am in my Angry/Impulsive Child Mode now, because *("Example: My therapist is not listening to me.")*



_____
_____
_____
_____
_____
_____
_____
_____

I really need *("Her to understand that this is really important to me.")*

○ _____
_____
_____
_____

My Healthy Adult Mode can take good care of my Angry/ Impulsive Child Mode by *("Telling her how I feel and that it is important instead of just yelling at her").*

_____

_____

_____

b Reactions of others to the ACM (Handout: IST-ACM2)

The ACM can cause significant interpersonal problems. It is important that patients understand that they can trigger modes in other people by their behaviors in the ACM. In handout Individual Schema Therapy ACM 2: Reactions of Others to My Angry Child Mode (IST-ACM2), different examples are given for you to figure out with your patient which mode the other person is in and what the patient could do from his/her HAM to de-escalate the conflict. Let your patient write the answers down. There are two empty rows for the patient's personal examples.

Individual Schema Therapy ACM 2: Reactions of Others to My Angry Child Mode

Sometimes our behaviors in Angry Child Mode get us in trouble with other people.

Situation	*Angry Child Mode's reaction*	*The other person's reaction*	*What mode is the other person in?*	*How could you react in Healthy Adult Mode?*
I have asked my roommate to clean the dishes. The dishes are not done.	I storm into my roommate's room and yell at her: "I can't believe it. You never do anything. You are just lazy."	My roommate yells back: "I don't care. You didn't do the laundry, although I asked you to. You are just lazy yourself."		

Situation	*Angry Child Mode's reaction*	*The other person's reaction*	*What mode is the other person in?*	*How could you react in Healthy Adult Mode?*
My mom is upset with me because I did not take an exam that was important.	I run into my room and shut the door. Behind the door I scream: "This is none of your business, mom. Why don't you leave me alone?"	My mom says: "Oh whatever. I don't care if you never get a degree."		
My boyfriend and I have an argument.	"Oh yeah, you are always right, aren't you. You are so clever! Maybe it is better if we break up."	"You are right. I am sorry. We should do it your way."		

5.5.2 Schema Therapy cognitive interventions

a Needs of the ACM (Handout: IST-ACM3)

Remind the patient that all children have core childhood needs. Some needs are more associated with VCM, some more with ACM. If these needs are still present in the current life of the patient, it is important to find out if and how the patient tries to meet these needs now. This is especially true for ACM, as we often try to get our needs met in a way that gets us in trouble when we are in ACM. Using Individual Schema Therapy ACM 3: Needs of the Angry Child Mode (IST-ACM3), go through the individual childhood needs for ACM and let your patient write down what his childhood and current experience with these needs is. Assess with your patient which needs are still important and how he/she tries to meet these needs. If there are problem areas, explain that you will help him/her find alternative ways to meet the need effectively in one of the following sessions (for example, by using the flashcard IST-ACM1).

Individual Schema Therapy ACM 3: Needs of the Angry Child Mode

All children have core childhood needs. These needs are very important and meeting them is necessary for normal healthy development. The Angry Child Mode is an innate child reaction to these needs not being met. Let us talk about the following childhood needs that are relevant for Angry Child Mode. How were these needs met in your childhood? If these needs still exist, how do you try to meet them now?

1. **Acceptance**

Childhood experience with this need:

_____
_____
_____
_____
_____

How I try to meet this need now:

_____
_____
_____
_____
_____

2. **Validation of needs and feelings**
Childhood experience with this need:

How I try to meet this need now:

3. **Respect for boundaries**
Childhood experience with this need:

How I try to meet this need now:

b The Need for Attention (Handout: IST-ACM4)

Attention is a legitimate need of the ACM, yet it is a need many patients have difficulty accepting and getting met. DyPM messages (for example: "You are a burden to others because you always want them to attend to you") and MCM (for example: "Don't show others you need their attention or they will leave you") both can interfere with patients' acceptance of their need for attention as being important and normal. With handout Individual Schema Therapy ACM 4: The Healthy Need for Attention (IST-ACM4) you can discuss the need for attention. Go through the questions and connect the patient's answers to the modes they arise from (such as DyPMs and MCMs). The last question focuses on healthy ways to meet the need for

Individual Schema Therapy ACM 4: The Healthy Need for Attention

Attention is a legitimate need and one that frequently underlies the Angry Child Mode. The way we try to get this need met is important. Let's talk about the following questions.

1. Do you accept your need for attention?

2. What does it take for your need for attention to be met?



3. How was your need for attention met as a child?

4. How is it met today?

5. What happens today when your need for attention is not met?

6. Have you ever tried to get this need met in unhealthy ways? What are they?

7. What healthy ways do you know to ask for attention?

_____
_____
_____
_____

Assignment

Practice using a healthy way from #7 and record the results.

_____
_____
_____
_____
_____
_____
_____
_____



attention. Identify the healthy ways your patient knows, and if he/she doesn't know any, suggest some. As an assignment, you can let your patient try one of the healthy ways in real life and tell you about it in the following session.

5.5.3 Schema Therapy experiential interventions

a Vent your anger exercise

When patients are in ACM, it is important that they get the chance to vent their anger fully. So while the patient is in ACM, the therapist stays very calm and conveys acceptance of the emotion. This means that the tone of voice is neutral and that the therapist asks only easy clarifying



questions such as: "Is there anything else you feel angry about?" "Is there anything else you want to say?" and so forth. In this step, it is crucial that the therapist is not too empathic, as this may trigger PPM and inhibit anger expression. The role of the therapist in this exercise is to stay present with the patient's anger and be ready to set limits if the expression of anger moves to action that is inappropriate or dangerous. By this we mean breaking objects, hitting the wall, yelling at you instead of venting, and so forth. If this happens, interventions like offering a soft object to pound rather than a wall that could cause damage to property or the patient's hands or empathic confrontation are needed. An example of an empathic confrontation would be: "I understand that you are very angry with me and want me to hear you, but when you are yelling I cannot really hear your complaint. Can you lower your voice a bit so that I can hear what you need from me?" Only after your patient has fully vented his/her anger should you respond in a warm, understanding, and empathic way. When people have vented anger fully, they reach a point of exhaustion. Assess whether your patient has reached that point by observing posture and gestures. That is the time to move to looking at the links between the current experience and biographical experiences of the patient to facilitate the patient moving into the VCM. Underneath the anger of the ACM in response to core needs not being met is the pain of the VCM that we want to reach to help the VC heal. An example statement is: "I imagine that it was not safe to express your feelings of anger and hurt with your father in childhood." Once the patient is in VCM the therapist can use limited reparenting skills for the VCM. A third step that may be possible in the same session is to analyze with the patient what part of the anger was biographically triggered and what part belongs to the present situation. In this step it is important to name the modes that are involved (for example, the patient's DyPMs). In a last step you can role-play assertive expression of anger. (See the role-play using IST-ACM1 in Section 5.5.1a.)

b Mode dialogue for the ACM

1. Have two therapy chairs and three extra chairs ready (for HAM, for ACM, and for another mode, in case another mode comes up). The patient is in ACM or describes a situation when he/she was in his/her ACM.
2. Ask your patient to do a mode dialogue for this situation. Name the modes. Make sure that the ACM is not sitting next to the DyPM.
3. Let your patient take the Angry Child chair first. Ask the patient to say everything that the ACM has to say. Make sure that the patient expresses the feelings and possibly the needs of the ACM. Name these for emphasis.
4. If possible, ask your patient to switch to the Healthy Adult chair. If patients cannot switch to the Healthy Adult Chair yet, let them watch you take the Healthy Adult chair. Support your patient moving toward being in HAM in steps, as described for the other modes in this chapter.
5. The final step is for the patient's HAM to meet the ACM's needs now ("I understand this is really not OK. I see that you are very angry and it is OK to be angry"). HAM needs to validate the feelings of the ACM and, at the same time, tell him/her that HAM sets limits to destructive behaviors if necessary ("… it is OK to be angry. But it is not OK to hit other people").The HAM can then clarify for the ACM what he/she thinks the need is and whether the behavior of the ACM will get the need met. Let HAM tell ACM what he/she will do to get the need met. Fulfill the needs of the Angry Child until the anger dissolves.
6. Go back to the therapy chairs. Ask your patient how that felt. Work out with your patient how he/she can implement the newly learned behavior in daily life (use the flashcard IST-ACM1).

5.6 The Happy Child Mode

5.6.1 Schema Therapy behavioral pattern-breaking interventions

a Evoking your Happy Child Mode (Handout: IST-HCM1)

Give handout Individual Schema Therapy HCM 1: Evoking Your Happy Child Mode (IST-HCM1) to your patient the week before you want to work on the Happy Child Mode. The patient can start with the assignment at the top of the handout page. The assignment is to evoke the Happy Child Mode by engaging in a fun activity. The patient writes down how he/she triggered

Happy Child Mode. In the next session he/she can tell you about it. The therapist can then do imagery work with the patient by helping him/her visualize the activity that the patient described. As in all imagery work, we try to have the scene described as fully and clearly as possible. Inquire about how the patient felt and try to anchor the feeling physically by asking him/her to be aware of where the feeling is located in the body. When possible, record the imagery exercise so that the patient can listen to it, or have him/her do the exercise again on his/her own on a regular basis.

Individual Schema Therapy HCM 1: Evoking Your Happy Child Mode

Look for activities that evoke (call him/her out to play) your Happy Child Mode. Activities that are fun, like playing games, watching funny movies or cartoons, outdoor sports, doing things with friends, listening to certain songs, playing with your pet ….

How do you evoke your Happy Child Mode?

_____

_____

_____

_____

Tell your therapist about Happy Child Mode experiences. Together, you can try to revisit the scene in imagery in which your Happy Child Mode was evoked. Try to visualize it as clearly as possible. Focus on your feelings. How did you feel? Where was that feeling in your body? Did you smile or laugh? How did smiling or laughing feel?

Do *not* write about your Happy Child image! Practice visualizing the same scene again the next day … and the day after … learn to feel positive emotions through imagery!



This is supposed to be a fun activity! If you notice your Demanding Parent popping up, saying things like "You have to be able to visualize it perfectly" or "Practice more, you need to get better at this!" – stop immediately and do something that is fun (watch TV, talk to someone, eat candies). If any of the Dysfunctional Parent Modes get in your way again and again, talk to someone about it and tell someone you feel comfortable with about your Happy Child scene.

b Playing a game

Let your patient bring his/her favorite game to the therapy session and play the game with him/her. Make it a really positive experience for him/her by making the scene very comfortable (for example, sit on the floor, have jelly beans or cookies ready, play the radio in the background).

Make the experience very personal for your patient. It is important that the patient can see a little of the personality of the therapist during this session and that there is a lot of fun. The only goal here is to create a positive moment in this session.

5.6.2 Schema Therapy cognitive interventions

a What my Happy Child Mode likes (Handout: IST-HCM2)

Bring different fun-related objects – such as funny books, postcards, music, videos, and possibly even different kinds of snacks or drinks (e.g., bubble gum, tea, smoothies, and so forth) to therapy. Explore which of these things help the patient access his/her Happy Child Mode. Talk about who and what the patient's Happy Child Mode likes (for example, "I like my friend Carly with whom I have fun picnics") and which activities the Happy Child Mode likes (for example, watching a funny movie like *Shrek*, jumping in a pool, dressing up for going to a party). Write everything down on the handout Individual Schema Therapy HCM 2: Likes of My Happy Child Mode (IST-HCM2).

Individual Schema Therapy HCM 2: Likes of My Happy Child Mode

My Happy Child Mode likes:



1. **People and pets**

_____

_____

_____

_____

_____

_____

_____

_____

_____

2. **Things**
   a. **Funny objects**

   ◯

   b. **Books**

   c. **Other things**

   d. **Drinks** (e.g., strawberry smoothie) or food (e.g., jelly beans)

3. **Activities**

   ◯

4. **Other things you can think of**

b Positive feedback for my Happy Child Mode (Handout: IST-HCM3)

In general, DyPMs have a lot of criticism for the HCM. This is one of the reasons that patients don't let their HCM come out very often and may not even have much access to this mode. It may not have been allowed, encouraged, or developed. Try to collect positive messages and encouragement from the HAM for the HCM with handout Individual Schema Therapy HCM 3: Positive Feedback for the Happy Child Mode (IST-HCM3). Have the patient write all the positive statements down. Examples can be "When you are around, the world looks much better to me," "When I smile at people in HCM, people smile back," "I like to feel happy. It is a great feeling." You can also collect statements from friends, other patients, or staff members about what they find positive about your HCM.

Individual Schema Therapy HCM 3: Positive Feedback for the Happy Child Mode

Your Dysfunctional Parent Modes have a lot of negative things to say about the Happy Child Mode. Your Happy Child Mode needs some positive feedback. Let's see what your Healthy Adult Mode can say to your Happy Child Mode:

1. *Example: "I love your happy smile."*
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____





11. _____
12. _____
13. _____
14. _____
15. _____
16. _____
17. _____
18. _____
19. _____
20. _____

5.6.3 Schema Therapy experiential interventions

a Indulgence training

Find little snacks that your patient likes, such as different kinds of chocolates or different kinds of fruit. Be careful with your choice of food if your patient has an eating disorder. The pieces can be very small. Let your patient close his/her eyes and try the different kinds of food. Start with having him/her smell the pieces and taste little bits. Then ask him/her to guess what he/she has just tasted.

b Imagery scripts

Have your patient bring something to the therapy session that symbolizes a positive moment in his/her life. It can be a photo, an object, "Evoking Your Happy Child Mode" handout, and so forth. Ask the patient to tell you about the positive moment the object represents and make sure that it is a moment when your patient was in the HCM. The positive moment can also be a moment with you or with peers in one of the groups. Next, re-create the scene as an imagery script.

If your patient cannot name a positive moment in his/her life and you have never seen him/her in the Happy Child Mode, then you can just be creative and do an imagery exercise about being on the playground or in a fun park together. Remember – if your patient cannot enter the image or does not like any of the activities, it is highly likely that he/she is in an MCM. If this happens, go back to one of the exercises to get through or around the MCM.

5.7 The Healthy Adult Mode (HAM)

5.7.1 Schema Therapy behavioral pattern-breaking interventions

a Behavioral experiments for HAM (Handout: IST-HAM1)

To further develop their identity, patients must take action. Read the text on handout Individual Schema Therapy HAM 1: Behavioral Experiments for the Healthy Adult Mode (IST-HAM1) to your patient and discuss the example. Then identify, with your patient, which new behavior he/she might want to try. Have the patient describe the behavior and the situation in which he/she wants to try it out in detail. The assignment is to try the new behavior in real life. In the next session you can find out how the patient felt after engaging in the new behavior, if any modes interfered, and what the result was – positive or negative (for example, positive or negative feedback from peers after wearing new clothes for the first time). Continue to talk about identifying new behaviors and trying them.

Individual Schema Therapy HAM 1: Behavioral Experiments for the Healthy Adult Mode

○ Try something new that is a HAM behavior. It can be an activity or a new dress or a new social skill – it just has to be something that you haven't tried before.

Example: Anne's Demanding Parent Mode told her she always had to be on time. Terrible things would happen if she wasn't always on time. Anne's new Healthy Adult behavior was to be 3 minutes late. She decided that she was going to be 3 minutes late for individual therapy, for a date with her boyfriend at night, and for work in the morning. After her behavioral experiments she wrote down how she felt and what bad things happened because she was 3 minutes late. Guess what – nothing terrible happened … and Anne felt alright allowing herself to be a little late from time to time.

Which new Healthy Adult behavior do you want to try? In which situations?

- _____
  _____
  _____
  _____

How did you feel after your behavior experiments?

- _____
  _____
  _____
  _____

Did you experience any consequences of your new behavior?

- _____
  _____
  _____
  _____



5.7.2 Schema Therapy cognitive interventions

a Getting to know your Healthy Adult Mode (Handout: IST-HAM2)

Most patients do not know a lot about their HAM because they spend so much time in DyPM and MCM. In this exercise, patients can get to know their HAM and positive parts of their identity better. In the first section of

handout Individual Schema Therapy HAM 2: Getting to Know Your Healthy Adult Mode (IST-HAM2), you ask your patient to list all positive, negative, and neutral qualities of his/her HAM. Make sure that he/she does not just list one category. If patients cannot think of anything, offer a few adjectives (e.g., tolerant, active, sensitive, loud) and ask them how they compare on these adjectives to their best friend or to you. The next section focuses on beliefs. If your patients can't think of any things that are important to them or that they believe in, suggest categories (e.g., "Is taking care of the environment important to you?" "Do you believe that travelling is a good way to experience other cultures?"). The last section focuses on how one wants to be (e.g., "I want to be successful in my job," "I want to be a loving parent"). Sometimes it is easier to clarify what one does not want (e.g., "I don't want to be arrogant"). After this section you can talk to your patient about what he/she would need to do to develop the positive parts of his/her identity to be able to be that new person. You can also do imagery work.

Individual Schema Therapy HAM 2: Getting to Know Your Healthy Adult Mode

What do you know about your HAM? List all positive, negative, and neutral qualities you know about (e.g., woman, brown-haired, caring, loud, impatient, indecisive, creative, musical …)

- _____
  _____
  _____
  _____
  _____
  _____



What is important to your HAM? What do you believe in?

- _____
  _____
  _____
  _____
  _____
  _____

How do you want to be (remember that you don't have to be perfect)? Sometimes it helps to list the things you do not want to be to help you find out more about what you want.

- _____
_____
_____
_____
_____

5.7.3 Schema Therapy experiential interventions

a HAM and the future (Handout: IST-HAM3)

In this session we focus on imagery exercises to visualize a positive future for the HAM, using handout Individual Schema Therapy HAM 3: Your Healthy Adult Mode and the Future (IST-HAM3). The therapist can lead the patient in imagining what his/her life could be like in 3, 5, 10, and 40 years. As with the previous imagery exercises, have your patient visualize the scenes in as much detail as possible and assess the feelings that occur. Make sure that your patient does not drift into negative feelings; if so, rescript the image. It is important that you have your patient focus on a life that would make him/her happy (i.e., in which he/she has significant relationships, enjoys work, leisure activities, and so forth).

After the imagery exercises, define with your patient which concrete steps he/she can take today or in the following week to be a step closer to the life in the imagery. Make it clear to your patient that you will support him/her as he/she takes these steps.

Individual Schema Therapy HAM 3: Your Healthy Adult Mode and the Future

Visualize positive memories that your Healthy Adult has. Imagine that your mind is like a slide projector – put in a positive slide of a memory and if a negative slide shows up, eject it and put the positive one back in. Remember that we don't have conscious control of

every thought that comes into our heads, but we can do something about whether we let it stay or replace it with something else.

Visualize a dream you have for a Healthy Adult future. What do you want your life to be like in 3, 5, 10, 40 years? What would make you happy?

What concrete steps can you take today to move a step closer to your dream future? You might need help when taking some of these steps – remember that you are not alone and that we support your efforts.



6

Training, Supervision, Research, and Concluding Remarks

Training and supervision are important for the competent implementation of the individual and group ST. In describing the patient population likely to be treated with the integrated ST program, particularly in higher levels of care settings, some of the adjectives used were "challenging," "chronic," "complex," "have failed other treatments," and personality disorder. It should be no surprise, given these, that adequate training and ongoing supervision are recommended.

6.1 Training

Recommendations for minimum training and supervision requirements have been made by the International Society for Schema Therapy. Of course, this manual and treatment program can be used while undergoing supervision. A complete description of ST certification is available at www.ISSTonline.com. Training and supervision in ST and GST are available all over the world and information about workshops and training programs is also available on the ISST web site.

6.2 Supervision

Regular supervision sessions, at least peer supervision or intervision, should be attended by all members of the treatment team. This is necessary to be able to coordinate individual and group treatment and, in higher levels of care settings, the milieu and multidisciplinary treatment team. Ideally, the supervisor or team leader establishes these sessions as a safe place to get support, discuss difficulties encountered, and learn and practice new interventions. At times there may be disagreements and conflicts in the team and supervision sessions are a place where we can be reminded to be respectful of each other, keep open communication, and lower tension. Using the ST

The Schema Therapy Clinician's Guide, First Edition. Joan M. Farrell, Neele Reiss, and Ida A. Shaw.
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model, some of the problems in this area can be attributed to modes being triggered. The therapist approach of limited reparenting asks the therapist to be present in ST as a genuine person. All of us have some schema modes and these can easily be triggered in doing ST, particularly in groups. A value in ST and an important component of ST training is that therapists cultivate awareness of their own schemas and modes and recognize when activation and triggering occur. This is a phenomenon of all therapeutic approaches whether recognized (e.g., the countertransference of psychodynamic approaches) or not. It is important that we learn to deal with such activation, and to consider the feedback from our co-therapists and team for times when we do not recognize our own mode activation. In group sessions, one of the therapist tasks is to have a signal for alerting their partner if they think a mode has been triggered that is negatively affecting the group. An example from two of us who are frequently co-therapists together is the triggering of the Demanding Parent Mode. Joan was rather unhappy with the pace of the patients' work in group and gave them an assignment of trying a new technique 10 times during the week. Since this assignment was delivered from the authoritarian presentation of DePM, most of the group froze. Ida said to the group: "Gee, do you think a mode might have been triggered in Joan?" When no one answered, she offered: "I think it is her DePM. What do you think, Joan?" Joan, fortunately, agreed and acknowledged her mode activation. This was a good learning experience for the patients as it gave them an experience of a therapist having a mode triggered and dealing with it. It also suggested to them that they could even ask their therapists about their mode activation. At times it may not be possible to point out mode triggering to another therapist while it is occurring. In that case, supervision sessions are a good place to give that feedback. All sorts of reactions fueled by schemas and modes take place between patients, between therapists, between patients and therapists. It is important to cultivate both a supportive patient group atmosphere and a supportive peer- or supervisor-led meeting for therapists.

Multidisciplinary teams present many benefits and some potential difficulties. One of the difficulties is disagreement about what mode a patient is in, as this assessment determines the requisite limited reparenting intervention. One therapist may assess a patient as being in VCM and respond with validation and support. Another may see an MCM and respond by setting a limit. This could lead to a productive discussion, with both therapists sharing their assessments and possibly their differing interpersonal experience of the patient, leading to both understanding the patient more fully. Disagreements can be opportunities to find solutions for complicated situations rather than being a source of tension or dissension in the team.

When such disagreements occur in group sessions, healthy negotiation and conflict resolution on the therapists' part can provide healthy models for patients and opportunities for vicarious learning.

When different individual and group therapists are involved in a patient's treatment, they must be aware of the potential for differences in perception and relationship. Patients react differently (both consciously and unconsciously) to different therapists and in group versus individual sessions. This is common and occurs for reasons like the match between therapists and patient in terms of temperament, interests, background, mode profile, the role the therapist has in the program, and how often they meet with the patient. All of these variables can affect how safe and comfortable the patient feels with a particular therapist. It is the task of therapists to meet the client's needs in these situations and be aware of their own feelings, of competition, jealousy, hurt, and so forth. Supervision sessions are a good place for these issues to be discussed and resolved.

6.3 Research on Schema Therapy

Schema Therapy was originally developed by J. Young *et al.* (2003) to treat patients with personality disorders and chronic psychological problems in an individual outpatient psychotherapy setting. The effectiveness of Schema Therapy for patients with borderline personality disorder (BPD) was first tested in a randomized controlled trial of individual ST in the Netherlands (Giesen-Bloo *et al.*, 2006). Three years of individual outpatient Schema Therapy was compared to individual transference-focused psychotherapy. Patients in both treatments showed improvement in all major domains of BPD symptoms, but Schema Therapy had lower drop-out rates and higher rates of recovery or significant improvement by the end of the study. Additionally, Schema Therapy patients reported an increased quality of life compared to transference-focused psychotherapy patients. Schema Therapy also demonstrated cost-effectiveness (van Asselt *et al.*, 2008). An implementation trial conducted in a general healthcare setting, also in the Netherlands, demonstrated similar effectiveness for individual Schema Therapy for BPD (Nadort *et al.*, 2009). Farrell *et al.* (2009) adapted Schema Therapy for the group modality and tested their Group Schema Therapy model in a randomized controlled trial for outpatients with BPD. In this trial, 30 sessions of GST were added to treatment as usual for one of two randomly assigned groups of patients. Significant reductions across all symptoms specific to BPD as well as global severity of psychiatric symptoms were found. The combined Schema Therapy treatment program with individual and group therapy sessions for patients with BPD described in

this manual was implemented and evaluated by Reiss *et al.* (2013a). In the three pilot studies reported, reductions in BPD-specific measures as well as general psychopathology were found and subjective patient satisfaction with the Schema Therapy treatment programs was high. Schema Therapy has thus demonstrated effectiveness in the treatment of patients with BPD across inpatient and outpatient treatment settings using individual, group, and combined formats.

Some research on Schema Therapy has been conducted in other patient populations. In a population of war veterans with post-traumatic stress disorder (PTSD), Cockram, Drummond, & Lee (2010) found that Schema Therapy within a group trauma treatment program had positive effects in reducing PTSD, depression, and anxiety symptoms. In a Cluster C personality disorder study, Schema Therapy demonstrated better effectiveness than treatment as usual regarding recovery from personality disorder symptoms and comorbid depression. The general assessment of functioning score also increased significantly more in the Schema Therapy Group and Schema Therapy treatment was more cost-effective than the comparison (Bamelis, Evers, Spinhoven, & Arntz, 2013). Schema Therapy outcome studies in other populations, such as forensic populations (Bernstein, Arntz, & de Vos, 2007), are under way. There is a need for outcome studies to evaluate the effectiveness of Schema Therapy, especially in intensive settings, and with less homogeneous populations, such as patients with different psychological disorders. Jacob and Arntz (2013) conducted a meta-analysis of published ST studies on BPD. They concluded that the average drop-out rate in ST is very low and compares favorably to dialectical behavior therapy (DBT), transference-focused psychotherapy (TFP), or mentalization-based therapy (MBT). The effect size of ST seems to be associated with treatment length. Yet other factors such as different assessment instruments could be influencing this, so this result should be interpreted cautiously. Jacob and Arntz (2013) also describe studies on mixed and Cluster C PDs which are in progress.

6.4 Concluding Remarks

This manual represents the sum of our experience integrating Individual and Group Schema Therapy programs in inpatient, day therapy, and outpatient settings over a 25-year period. We have attempted to design a program flexible enough to meet the needs of a variety of settings and lengths of treatment and the challenges of today's naturalistic clinical settings instead of the more controlled settings of research studies. We have tried to be as explicit as possible in the therapist notes sections, providing sample scripts

and management tips. We provide patient handouts and assignments for every individual and group session. Our experience in training novice therapists is that such material is extremely helpful. However, training workshops and supervision are an integral part of competence development, especially in a complex form of psychotherapy like ST, which strategically integrates cognitive, experiential, and behavioral pattern-breaking interventions. We anticipate that experienced group and individual schema therapists will be able to use the material more flexibly and make it their own. Another goal we had in designing this manual was to provide a structured protocol that can be evaluated in outcome studies.

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