THE SCHEMA THERAPY BULLETIN

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This issue- Schema Therapy with Marginalized Populations

Marginalized populations are those excluded from mainstream social, economic, cultural, or political life. (Marginalized Populations by Kay E. Cook In: The SAGE Encyclopedia of Qualitative Research Methods Edited by: Lisa M. Given). More specifically exclusions can apply to educational opportunities, access to health/mental health care, membership in community groups or clubs, employment opportunities, or feelings of comfort, trust, and "fitting in" to the society in which members reside. This feeling can be described as "Minority Stress". Groups can experience exclusion and alienation by virtue of their gender, gender identity, race, religion, education level, appearance or social status, and the list goes on.

In this issue of the Schema Therapy Bulletin, contributors will describe the application of the Schema Therapy model with three marginalized populations: Transgender and Gender Diverse Individuals, Latinos living in the United States, and Military Veterans.

After providing an overview of the distinction between anatomy and identity, Cesar Gonzalez outlines the predominate mental health symptoms prevalent in the transgender population, and explores their relationship to unmet core needs and specific schema development. Describing his

In this April 2018 Issue

work with Adam, a young man beginning hormone therapy to continue his transition from female to male, Cesar demonstrates Gender Affirming Schema Therapy in addressing the maladaptive schemas that arose from his gender dysphoria and his parents' unwillingness to accept his identity as he experienced it.

Megan Fry and Suzy Redston report on the symptoms likely to bring a soldier to a mental health professional, and describe the coping modes associated with military veterans. They note that in some cases individuals with unmet core needs may be drawn to military service. The structure and functioning of the military, the trauma of war, and the struggle to readjust to civilian life after service can all be stimuli for the manifestation and elaboration of unmet core needs, schemas, and maladaptive coping modes. The case of Ryan, a 44 year old army veteran illustrates these struggles.

Carlos Rojas addresses the important balance between understanding and accepting cultural norms and stereotypes, and seeing each member of the culture as a unique person. Specifically he writes about the culture and values of the Latino community; it's cultural resistance to mental health care, and it's emphasis on family, respect machismo (a man's position in the family), and marianismo, the role and function of women in the family). He goes on to propose that Latino culture may be characterized by particular schema profiles. This understanding can help to facilitate treatment.

Our next issue will focus on New Developments in Schema Therapy. If you are interested in submitting an article for this or any future issue, please email us!

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Dresses, Spiderman, and Gender Dysphoria: A Gender-Affirming Schema Therapy Approach

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Anatomy is Not Identity

After weeks 6 to 7 weeks into a fetus' development, the expression of a gene induces changes that alter the trajectory of the development of a fetus' sex characteristics and how expectant parents will eventually respond to the socially acceptable question of, "Are you having a boy or a girl?" In other words, "Are you expecting a baby with a penis or a vagina?" The moment this question is answered is when there are social rules put on the expectant parents and the unborn child. These sex characteristics guide social expectations of *"what boys do"* and *"what girls do"* and impact how individuals view themselves, others, and their futures – as well as which colors or clothing they will use, which recreational activities they will pursue, what occupations they will be encouraged to follow, and even how much emotion is acceptable to express.

At approximately 2 to 4 years of age, most children will have already internalized stereotypes of *"what boys do"* and *"what girls do"* and will have professed their gender to their parents. For most children, gender expectations based on sex characteristics informs their *gender identity*, defined as the internal sense of being a boy or girl. The term *cisgender* is used to describe congruence among individuals whose gender identity is in line with their sex assigned at birth (e.g., most individuals are *cisgender* women or *cisgender* men). The term *transgender* is used to describe individuals who report that their gender identity is incongruent with their sex assigned at birth. Among transgender individuals, many report distress due to the incongruence between their sex characteristics and gender identity – this distress is termed *gender dysphoria.*

"At approximately 2 to 4 years of age, most children will have already internalized stereotypes of *"what boys do"* and *"what girls do"*

If one were to randomly select 100,000 adults living in the United States, it is estimated that approximately 580 adults would identify as transgender. For adolescents (ages 13-17), the prevalence estimate is that for every 100,000 there are 730 adolescents that identify as transgender. While the prevalence of those who identify as transgender may appear relatively low, the likelihood of mental health clinicians seeing patients in their practice is moderately high due to the psychosocial difficulties that many

Schema therapy is consistent with the contemporary goal of treatment of reducing gender dysphoria through providing gender affirming care, *not* through changing the patient's gender identity.

transgender individuals report. For example, multiple studies have suggested that the lifetime prevalence of attempted suicide among transgender individuals is anywhere between 40-50%. The estimated 12-month rate of depression among transgender individuals is approximately 47% and is significantly higher than the estimated 8.7% among the general population. In addition to the elevated rates of mental health concerns, transgender individuals will often seek out medical interventions such as hormone therapy or surgery to alleviate gender dysphoria – in turn, most physicians and surgeons require that there be a diagnosis of gender dysphoria diagnosed from a mental health clinician before they will render services.

It is out of the scope of this newsletter article to provide a comprehensive explanation of best practices for providing care to transgender and gender diverse individuals, however, for schema therapists interested in understanding the basics, I refer you to the American Psychological Association's *Guidelines for Psychological Practice with Transgender and Gender Nonconforming People* which is available at: https://www.apa.org/practice/guidelines/transgender.pdf In addition, the Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People is available for free on the website of the World Professional Association for Transgender Health (www.wpath.org).

The goal of this newsletter article is to illustrate an example of how schema therapy is consistent with the contemporary goal of treatment of reducing gender dysphoria through providing gender affirming care, *not* through changing the patient's gender identity.

Early Maladaptive Schemas among Transgender and Gender Diverse Individuals

Given the high levels of stigma, prejudice, and discrimination that transgender individuals experience, known as *minority stress,* it is expected that maladaptive schemas among transgender and gender diverse individuals are elevated compared to the general population. While no large studies have examined these hypotheses, there are small observational studies from multiple countries that provide evidence for this hypothesis. For example, a study published in 2011 comparing transgender and cisgender individuals living in the county of Hungary suggested that transgender individuals had higher endorsement of emotional deprivation, defectiveness/shame, social isolation/alienation, vulnerability to harm/illness, self-sacrifice, and approval/recognition seeking. In addition, there is data that suggest difference among maladaptive schemas between transgender women and men. A study published in 2013 found that when examining 15 schemas between transgender women and men living in the country of Iran, transgender women reported significantly higher endorsement of maladaptive schemas in the disconnection and rejection domain.

In a sample of transgender patients with gender dysphoria in my clinical practice (94 transgender women and 64 transgender men) approximately 42% are classified as having current suicide risk. Out of the 42% with suicide risk, approximately 21% are at moderate or high risk for suicide. Mental

health clinicians who are not trained in working with vulnerable populations may assume that this elevated risk is an indicator of psychopathology, however, research among vulnerable populations suggests psychosocial stressors resulting from being in a minority group (minority stress) influences risk factors for suicide. From a schema perspective, one could hypothesize that it's the persistent unmet core needs and the coping response style that influence the observable behaviors. Data from a study that I am working on publishing suggests, that if we hold all schemas constant, self-sacrifice, failure, and social isolation are associated with an increase odds of being classified for current suicide risk; interestingly, dependence/incompetence is a protective factor for current suicide risk. Further, while holding all 18 schemas constant among those with current suicide risk, emotional deprivation schema is associated with severity of suicide risk (i.e., increased emotional deprivation is predicts severity of risk for suicide). Schema modes were not associated with current suicide risk.

Gender-Affirming Schema Therapy

Currently there are no controlled studies to exam whether gender dysphoria is associated with a specific schemas, however, if there were, the influence of minority stress would likely make it difficult to examine this relationships. The goal of engaging in gender-affirming schema therapy is not about healing schemas in order to modify gender identity – rather, the goal is to facilitate healing through countering minority stress experienced in an unsupportive sociocultural environment that values the gender binary. Really, the goal of gender-affirming schema therapy is the same as with any other schema therapy goals which is to help patients identify, weaken, and break schema-driven maladaptive patterns in order to build a health adult that experiences autonomy, belonging, and competency in their everyday life. The only difference is that our focus is on working with the patient to help them counter negative messages about themselves, to help them explore the gender identity and expression that is most congruent with them, to help them navigate the complex medical systems that can oftentimes perpetuate maladaptive schemas, and to provide affirmation. One of the most affirming interventions one can provide an individual is to simply ask what their preferred name and gender pronouns are. From a schema perspective, this helps communicate to the patient that you want to understand them for who they feel they are, without any conditions. In sum, you can think of gender-affirming schema therapy as schema therapy with an added awareness and understanding of the basic assumptions that we as a society have about gender stereotypes.

Case of Adam (pseudonym used)

Sex Assigned at Birth: Female

Gender Identity: Male

"Adam" is the name that the patient chose – he asked that I use masculine pronouns – he/him/his.

Adam was referred to me because he had recently moved away from his home and was seeking to start hormone therapy in order to masculinize his body – his physician needed a letter of support from a mental health professional to initiate testosterone. During the first appointment with me, Adam reported to me that he recently left his home state after his father attempted to strangulate him over a disagreement about Adam not dressing in the manner that the family preferred. Adam tearfully recalled his father screaming the words, "You are bringing shame to this family and I would rather have you be dead."

One of the most affirming interventions one can provide an individual is to simply ask what their preferred name and gender pronouns are

In our appointments, Adam would frequently recall his childhood being filled with what felt like riddles and involved questions about whether he should engage in the rituals of gender expression. Should he wear the dress that he was told he should wear? Should he play with the toys that he liked, or the ones that he was told to like? He recalled that just before puberty he tried to "act like a girl". "I tried so hard to wear the dress, it was during this time that my mother was the proudest of me. But even when I was in a dress, my mom would tell me: 'You have a masculine body – you will have to stay at home because no man or their family will want you'". Through the first few sessions Adam would repeat the words, "I tried, I tried... I tried liking wearing dresses and makeup, but it was not me." He recalled that he had felt different about himself since the age of four and it wasn't until he was an adolescent did he attempt to present in a more stereotypic masculine appearance. It was during this time that family arguments became common. Adam reported that it wasn't until he went away to college reported that he felt relief from the constant family discord - even then, when he would post on social media his parents would ask him to remove pictures of himself with friends because he appeared "too masculine". Adam learned to tell lies about himself in order to appease his parents. It wasn't until Adam graduated college that he felt empowered to inform his family that he identified as male and that he had the goal of transitioning to a masculine sounding chosen name and pronouns. This is when his father attempted to strangulate him and he left to another state under the guise that he would be going away to graduate school.

Adam's schemas included mistrust/abuse, defectiveness, subjugation, abandonment/instability, emotional deprivation, social exclusion, and self-punitiveness. In addition, throughout our therapy sessions we discovered the role of enmeshment/undeveloped-self. Adam's frequent modes were the vulnerable child, angry protector, detached protector/self-sacrificer.

Gender Affirmation in Imagery Rescripting

During a therapy session that focused on the role of culture and rituals and the expectations that come with them, Adam and I engaged in imagery rescripting. The emotional trigger as an adult was seeing pictures from his friend's Facebook post about his family being at a party and recalling that he was not there with them because of the way he expressed his gender.

I engaged Adam in an imagery exercise linked to this trigger and he recalled that the memory was when he was about 5 years of age and he had family coming over for a party. He recalled that his mother called him into her room and showed him a pink dress that she had bought for him to wear to a family photo. Adam recalled persistently asking, "Can I change now?" after each click of the camera. It was at this time when he recalled that his mother took him upstairs and "mom beat the crap out of me".

During the imagery rescripting, as Adam's schema therapist, I had to decide what would be most affirming to Adam – my first thought was that I should use Adam's birth name, "Sofia" along with feminine gender pronouns – it wasn't until I was in the image with little Adam that he informed me that he needed to hear from his mother that she loved him the way that HE was ,and she would allow for him to wear jeans to the family picture, instead of a pink dress. It was during the imagery rescripting exercise that I affirmed Adam's gender – "A child should not have to worry about being themselves" – after a warm hug and affirmation in the imagery all Adam wanted was to go down a slide while wearing a Spiderman outfit – "You are so special – a special child- you are allowed to be yourself- I will accept you no matter what- you can dress up like Spiderman anytime you want."

I worked with Adam for over 2 years now. He has gone on to receive surgery to remove his breasts- he has been on hormone therapy and has set limits with his parents; he has developed his self by changing his name and gender marker on his identification. Adam is currently navigating the developmental milestones of dating and throughout this has developed a sense of stability for himself by joining a transgender affirming church and building a chosen family.

Adam's parents have informed him that they will only meet with him if he transitions back to presenting female.

Recent Schema Therapy Research and Papers

Alba, J., Calvete, E., Wante, L., Van Beveren, M. L., & Braet, C. (2018). Early Maladaptive Schemas as Moderators of the Association between Bullying Victimization and Depressive Symptoms in Adolescents. *Cognitive Therapy and Research*, *42*(1), 24-35.

Bach, B., & Farrell, J. M. (2018). Schemas and modes in borderline personality disorder: The mistrustful, shameful, angry, impulsive, and unhappy child. *Psychiatry research*, *259*, 323-329.

Bach, B., Lockwood, G., & Young, J. E. (2017). A new look at the schema therapy model: organization and role of early maladaptive schemas. *Cognitive behaviour therapy*, 1-22

Carter, J. D., McIntosh, V. V., Jordan, J., Porter, R. J., Douglas, K., Frampton, C. M., & Joyce, P. R. (2018). Patient predictors of response to cognitive behaviour therapy and schema therapy for depression. *Australian & New Zealand Journal of Psychiatry*, 0004867417750756.

Calvert, F., Smith, E., Brockman, R., & Simpson, S. (2018). Group schema therapy for eating disorders: study protocol. *Journal of eating disorders*, *6*(1), 1.

Louis, J. P., Wood, A. M., Lockwood, G., Ho, M. H. R., & Ferguson, E. (2017). Positive Clinical Psychology and Schema Therapy (ST): the development of the Young Positive Schema Questionnaire (YPSQ) to complement the Young Schema Questionnaire 3 Short Form (YSQ-S3). *Psychological Assessment*.

Phillips, K., Brockman, R., Bailey, P. E., & Kneebone, I. I. (2017). Young Schema Questionnaire–Short Form Version 3 (YSQ-S3): Preliminary validation in older adults. *Aging & mental health*, 1-8.

Renner, F., DeRubeis, R., Arntz, A., Peeters, F., Lobbestael, J., & Huibers, M. J. (2018). Exploring mechanisms of change in schema therapy for chronic depression. *Journal of behavior therapy and experimental psychiatry*, *58*, 97-105.

Sundag, J., Zens, C., Ascone, L., Thome, S., & Lincoln, T. M. (2018). Are Schemas Passed on? A Study on the Association Between Early Maladaptive Schemas in Parents and Their Offspring and the Putative Translating Mechanisms. *Behavioural and Cognitive Psychotherapy*, 1-16.

Younan, R., Farrell, J., & May, T. (2017). 'Teaching Me to Parent Myself': The Feasibility of an In-Patient Group Schema Therapy Programme for Complex Trauma. *Behavioural and cognitive psychotherapy*, 1-16.

Schema Therapy and Latino Patients... A Cultural Approach

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A primary challenge in working with patients from different cultural backgrounds is being able to use cultural generalizations appropriately without losing sight of the individual patient. To succeed in this challenge, clinicians must keep in mind that variations occur between cultural subgroups just as individuals subscribe to group norms to varying degrees. Consideration of culture is essential in the process of diagnosis and treatment of culturally diverse patients. In the past decade the consideration of cultural factors has gained recognition in a variety of disciplines. In this article you will find a discussion of Latino cultural factors that are influential in the development of early maladaptive schemas (as defined within the Schema Therapy Model) and the propensity for specific schemas to develop within Latinos as a cultural group.

Overall, the Latino community does not talk about mental health issues. There is little information about this topic. Many Latinos do not seek treatment because they don't recognize the signs and symptoms of mental health conditions or know where to find help. This lack of information also increases the stigma associated with mental health issues. Many Latinos do not seek treatment for fear of being labeled as “locos” (crazy) or as having a mental health condition because this may cause shame. One in 5 people is affected by mental illness. Among Latinos cultural beliefs often influence mental health issues, el dicho "la ropa sucia se lava en casa” (similar to “don’t air your dirty laundry in public”). Latinos as a group tend to be very private and often do not want to talk in public about challenges at home. Cultural differences may lead to misdiagnosis among Latinos. For instance, Latinos may describe the symptoms of depression as “nervios” (nervousness), tiredness or a physical ailment. These symptoms are consistent with depression, but mental health providers who are not aware of how culture influences mental health may not recognize that these could be signs of depression.

While Latino communities show similar susceptibility to mental illness as the general population, unfortunately, they experience disparities in access to treatment and in the quality of treatment they receive. This inequality puts Latinos at a higher risk for more severe and persistent forms of mental health conditions. As a community, Latinos are less likely to seek mental health treatment. A 2001 Surgeon General's report found that only 20% of Latinos with symptoms of a psychological disorder talk to a doctor about their concerns. Only 10% contact a mental health specialist. Yet, without treatment, certain mental health conditions can worsen and become disabling.

Failure to understand and respond appropriately to the normative cultural values of patients can have a variety of adverse clinical consequences. Latinos tend to be highly group-oriented. A strong emphasis is placed on family as the major source of one's identity and protection against the hardships of life. This sense of family belonging is intense and limited to family and close friends. People who are not family or close friends are often slow to be given trust. The family model is an extended one; grandparents, aunts, cousins, and even people who are not biologically related may be considered part of the immediate family. The term Latinos use to describe their supreme collective loyalty to extended family is ***familismo***. Financial support of the family by the individual and vice versa is important and expected. The decisions and behavior of each individual in the extended family are based largely on pleasing the family; decisions are not to be made by the individual without consulting the family. In Latin American cultures, people tend to expect status differences between members of a society which is very different from U.S. American culture. Latinos place a high value on demonstrating ***respecto*** in interactions with others, which literally translates into respect. ***Respecto*** means that each person is expected to defer to those who are in a position of authority because of age, gender, social position, title, economic status, etc. Healthcare providers, and doctors especially, are viewed as authority figures. Thus, Latino patients/parents will tend to demonstrate ***respecto*** in healthcare encounters. They may be hesitant to ask questions or raise concerns about a doctor's recommendations, being fearful that doing so might be perceived as disrespectful. They may nod to demonstrate careful listening and respect when a doctor is talking, rather than agreement about treatment. ***Respecto*** is also expected on a reciprocal basis by Latinos when dealing with healthcare professionals. This is especially the case when a young doctor is treating an older Latino patient. It is important to approach Latino patients/parents in a somewhat formal manner, using appropriate titles of respect (Senor [Mr.] and Senora [Mrs.] and appropriate greetings [good morning or good afternoon]. This is especially true with older Latinos.

Latino families are often stratified based on age and sex. Generational hierarchy is expected – grandparent, child, grandchild. The oldest male (direct relative) holds the greatest power in most families and may make health decisions for others in the family. Latino men traditionally follow the ideal of ***machismo***. They are expected to be providers who maintain the integrity of the family unit and uphold the honor of family members. Many Latino females, at least publically, are expected to manifest respect and even submission to their husbands, though this compliance varies by individual and is affected by acculturation in the U.S. Women follow the ideal of ***marianismo*** which refers to the high value Latino women place on being dedicated, loving and supportive wives and mothers. They are responsible for teaching Latino children culture and religion and for being ready to help those in need both in the family and community. It bears repeating that upward mobility, education and other societal factors are changing the above, but in isolated communities and among new immigrants, little has changed.

ST has demonstrated relatively low levels of attrition (e.g. Giesen-Bloo et al., 2006) with populations who may otherwise struggle to engage in therapy, making it a promising approach for Latinos. Because the ST model assumes that all people develop schemas in childhood (Arntz & van Genderen, 2009), an explicit focus is put on schema development, often involving family relationships. Strategies are employed to defuse dysfunctional, self-defeating patterns fueled by early maladaptive schemas that formed due to unmet needs (Young et al., 2003). The ST focus on interpersonal and family relationships makes it particularly relevant to Latinos because of the cultural value of familism, a deep sense of loyalty, solidarity, and reciprocity among Latino family members (Sabogal, Marin, Otero-Sabogal, Marin, & Perez-Stable, 1987). A careful understanding of familism is considered crucial for successfully recruiting and retaining Latinos in psychotherapy research (Miranda et al., 1996) but the topic is complex. Adherence to familism can bring benefits that are protective (Gallo, Penedo, Espinosa de los Monteros, & Arguelles, 2009) such as family cohesion and support (Sabogal et al., 1987), but it can also present challenges. Overt or covert cultural expectations regarding obligations or gender roles in the family starting in childhood can create emotional conflict with potential to influence adult relationships (Gil & Vazquez, 1996). The focus on schemas allows a way to deal with familism within ST.

It has been my experience that as a result of these cultural phenomenon Latinos are characterized by particular schema profiles. One must be careful not generalize or jump to conclusion as each individual carries unique characteristics, however cultural factors play a major role in the development of certain schemas among Latinos. Below I will present a short discussion on schemas and the Latino Cultural factors that influence their development and maintenance. This is by no means an exhaustive or comprehensive list; it serves a perspective for further discussion and to raise awareness on the topic.

Afterwards, we imagined the smurfs in different spots of the therapy room, although it was at that stage not yet clear whether classical chair work exercises would work at all, since the patient was in a wheel chair

Young describes the maladaptive schema category of "***Impaired Autonomy and Performance***" as: The expectation of an individual's ability to separate, survive, function independently and/or perform successfully away from their environment is impaired. The schema of ***dependence/ incompetence*** can be found in this category and is characterized by: The expectation that an individual's ability to separate, survive, function independently and/or perform successfully away from their environment i s impaired. People with this schema often rely on others excessively for help in areas such as decision-making and initiating new tasks. Among Latinos this schema is influenced by the concept of ***familismo*** which requires individuals to make decisions and behave in ways that please the family rather than address his or her individual needs. The concepts of ***machismo*** and ***marianismo*** also influence this schema as they require men to focus their attention on the financial and protection needs of the family and women to place a greater enfaces on the physical and developmental needs of the family which often sacrifices their own needs. This approach does not encourage individuals to act independently and develop confidence in their ability to take care of themselves. But rather it sends the individual the message that their individual happiness will come as a result of focusing on the needs and loyalty to the family. Among Latino patients this schema is often characterized by feelings of dependence and impaired autonomy. Patients are often report feelings of enmeshment and often experience some level of impairment in making life through different life stages.

Young describes the maladaptive schema category of "***other directedness***" as: The individual is overly invested on the desires, feelings, and responses of others at the expense of their own needs; in order to gain love and approval and maintain their sense of connection or avoid retaliation. The schema of ***self-sacrifice*** can be found in this category and is characterized by: the excessive sacrifice of one's own needs in order to help others. Among Latinos this schema is promoted by the concepts of ***respeto***, which expects the individual to often sacrifice their own needs and defer to the needs of those in charge or the needs of family and/or community. The concepts of ***machismo*** and ***marianismo*** also influence this schema as they require men to focus their attention strength and women to place a greater enfaces on the needs of the family which often sacrifices their own needs. This approach sends the individual the message that their individual happiness will come as a result of placing the needs of others above those of their own. Among Latino patients this schema is often characterized by feelings of guilt and resentment. Patients are often left feeling that their intimate relationships will only work if they are overly invested in the needs of others. That in order to gain love, approval and maintain a sense of connection they need to place the needs of others above their own.

Young describes the maladaptive schema category of "***Overvigilance and Inhibition"*** as: The individual has an excessive emphasis on suppressing spontaneous feelings, impulses, and choices or meeting rigid, internalized rules and expectations about performance and ethical behavior, often at the expense of happiness, self-expression, close relationships, or health. The schema of ***Emotional Inhibition*** can be found in this category and is characterized by: the belief that you must suppress spontaneous emotions and impulses, especially anger, because any expression of feelings would harm others or lead to loss of self-esteem, embarrassment, retaliation or abandonment. Among Latinos this schema is promoted by the concepts of ***respeto***, which expects the individual to defer to individuals in a position of power often sacrificing the needs of the individual for the needs of those in charge. The concepts of ***machismo*** and ***marianismo*** further influence this schema as they require men to be strong and maintain the integrity of the family and the later concept requires women to place the needs of the family above all else. Among Latino patients this schema is often characterized by feelings disconnection and isolation. Patients are often left feeling that their intimate relationships will not adequately meet their needs for empathy, nurturance or protection.

Treat the Soldier & unlock the Healthy Adult

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Generally, when a person with a military background comes for psychological treatment they have been unwell, with clinically significant symptoms for at least 12 months. There is a significantly higher 12-month prevalence of all mental illnesses compared to the general Australian population. For example, the prevalence of major depression (MDD) was 6.4% compared to 3.1% in general population (1). Generally military personnel will

Schema Special Interest Groups- get involved!

There are a number of Schema

Therapy Special interest groups

that meet regularly to discuss

specific aspects of schema

therapy. These include

- couples work
- forensic work
- Trauma
- eating disorders
- child and adolescent

To be a part of these group visit the ISST website.

Research Blog

For recent developments in Schema Therapy research see the new ISST research blog- www.schematherapysociety.org/Research-Blog

present for treatment with more than one of the following problems; trauma, unstable mood, anxiety, alienation, hyperarousal or substance use including alcohol. When working with people who have been in any kind of military, it can be very difficult to soothe maladapted modes and release the Healthy Adult. For the purposes of this article we shall discuss people who have been in the Army when they developed their psychological problems, however the general concepts can apply to other arms of a Defence Force. We shall aim to conceptualise the schema presented in terms of what draws people to join a Defence Force which can give clues to early maladapted schemas; how the training to be a soldier causes and strengthens maladapted coping modes and how these coping modes are not conducive with a healthy civilian adult. The final stage shall be a case study by one author (MF) to illustrate some of our ideas.

People are attracted to the army for many reasons, however they all have to become defenders of the land. The army is a fighting force of people that are primarily land based and it functions as a complex system based on hierarchy, rules, group cohesion and limits on all emotional experiences. There are certainly many who are seeking the safe attachment and sense of competence the army will provide. The rules and regulations provide a set of predictable limits far more containing than those of the civilian society, as they are based on survival while protecting the life of others. There is little play or spontaneity in the army and hence people with basic schemas within the domain of hypervigilance and inhibition are able to surrender without necessarily being victimised. Disconnection, rejection and failure schemas can be overcompensated for and will be rewarded with early promotions. Those with impaired autonomy and achievement may also find the support and structure from the army containing and helpful; at least until it becomes clear that it is an organisation and not a family.

Throughout a career in the army, many early maladapted schemas can be soothed or maladapted coping modes supported, but at risk is the absence of an environment conducive to the development of the Healthy Adult. The soldier is not allowed to express emotions in an uncontained or free manner nor may he feel certain emotions especially while in the theatre of war. This has significant consequences following a soldier's career.

There are many people who seek out the army as it provides an environment that is opposite to their dysfunctional childhood. There are clear rules and expectations. If you work hard and follow them there is a predictable career progression and you are immediately part of a lifelong culture. The system of the army acts both as a demanding parent and a detached protector – not worrying about you individually but allowing those that surrender to the structure to be promoted, kept safe and working within a group of people with singular goals. Thus, the very nature of creating a soldier from basic training, where people are subjected to controlled bullying thereby causing a group of basic trainees to form a common defence against a common enemy, to the end of a soldiers career, they are encouraged to develop or strengthen maladapted coping modes including:

What can they all do together when strong fears and panic thoughts arise? How could the parents support their son's capacity, to activate and move the *clever & wise* mode to the fore

1. Detached protector to prevent any emotions occurring being felt and at times not even acknowledged.

2. Demanding parent who is the "screaming sergeant or corporal" from basic training making you keep going even when both your core biological & psychological needs are not being met.

3. Punitive critic who is the internalised advisor providing the rules and regulations why you did or did not get your promotion.

4. Detached self-soother who is active in the gym, or the bar pushing the soldier to go further and harder.

The experience of war and acting in the roles that the soldier has been trained for can cement some of these maladapted coping modes and cause others to develop once they return home. This process can be the beginning of a serious mental illness, where the woman who can no longer bathe her children as she sees the dead child from Timor, or the man who cannot have BBQs any more due to the burning smell in Vietnam. Then when the soldier discharges from the Army to become a civilian all the coping modes that he or she had developed for survival are now life interfering. The Healthy Adult mode will often try to assist by intellectualising & minimising the problem while the relationships around them deteriorate.

Treatment of the soldier needs to begin with a clear conceptualisation, where the maladapted coping modes are given a clear origin initially in the Army. If there are clear childhood triggers for schemas then of course linking helps, however it is often more useful to start with these modes coming from army experiences of core needs not being met and then with increasing therapeutic alliance and the

person becoming adapted to the way of schema therapy starting to link back to key childhood experiences. Rescripting an event can be traumatising if tried too early in treatment and often using letters or linking the bodily sensations to a thought can build the person's resilience for therapy.

Finally there is often a very clear understanding of the world that the army develops in the soldier that is: the world has good people and bad people, we are the good people, we are right when we defend those who we defend, our role is to protect those who are weak, infirm and unable to protect themselves. This is often linked to the soldier identity and when, through the experience of deployment and/or natural development of more of the healthy adult the soldier starts to question these *"truths"* the reaction can be catastrophic and can trigger a major mental illness. Thus in conceptualising to the person that the soldier in one way represents a complex interaction of modes and schema they can resolve the problems without the loss of their identity.

Case Example

Ryan* is 44 years of age. He joined the Army at 26 years due to being bored and seeking stability and a challenge. Prior to the Army he had a lot of casual jobs and an undeveloped sense of self. The military provided Ryan with a stable base, structure, a family, a purpose, boundaries and an identity... a soldier. These core needs had been largely absent from his life prior to the military. Ryan thrived in the military for 14 years and completed eight operational deployments, most of which were to Afghanistan. Ryan loved his job as it made him feel happy, worthwhile and like he was achieving something.

He was able to stop needing rules and accept the complexity that is life – full of grey areas.

On his last rotation to Afghanistan, Ryan witnessed the death of two of his mentors and upon return to Australia started to have difficulties at work. He had already recently separated from his wife, with the disconnection at home increasing throughout his military career, which he was not willing to lose or give up. Then without his mentors in the workplace supporting and guiding him things started to

unravel. He had lost the "family" and his stable base. He was now struggling within an organisation that wanted him to perform and meet their expectations, despite the emotional and physical hardship he had endured throughout his career. The organisation was not empathic or patient. They needed a soldier to perform and because Ryan could not, he was punished and rejected. In a desperate attempt to save his career and prove himself, Ryan elected to do one final tour of Afghanistan, but he was sent home early with no apparent logic provided for the decision. Feeling ashamed, useless, a failure and not good enough, his mental health plummeted and he accessed increasing support from medical and psychology, until such time he was medically separated with chronic PTSD, major depression, and alcohol abuse. Exacerbating his conditions was the absence of a Healthy Adult.

Ryan left the military with many maladaptive schemas and coping modes, which were not conducive to the civilian world. His Angry child caused significant issues on the road and in any interpersonal situation, particularly when people, or even himself, did not live up to his expectations. His Detached Protector had derailed his first marriage and made it difficult for him to process the trauma and losses he had endured in his life and in particular in his military career. His Compliant Surrender allowed him to be railroaded and subsequently let down by others, which has cost him financially, emotionally and physically. His Detached Self-Soother abused alcohol to numb his emotions, at the cost to his health and placing his life at risk (as he would become suicidal). His Over Controller has sought to find tasks to complete to the highest standard, driven by his demanding parent, with no consideration of his well-being, the impact on his relationships or the cost endured. Whilst throughout, his punitive parent punishes him for his flaws, mistakes, poor decisions, inadequacies and emotions.

Ryan has attended numerous services, in Australia and even overseas to get treatment for his PTSD, depression and alcohol misuse. He has had individual treatment, inpatient treatment on a number of occasions, and regular management by his GP, Clinical Psychologist and Psychiatrist. He has attended a range of personal and professional development activities, including retraining (e.g. Diploma in Business and Management), attending wounded soldier activities (e.g. trekking the Kokoda trail) and skills training (e.g. meditation). He even has a veteran companion dog. Despite years of therapy (approximately four to five to date), the reduction in his trauma symptoms, and the development of a Healthy Adult, Ryan still today struggles with his Compliant Surrender and Over Controller modes, both of which originate in the military.

Ryan's Compliant Surrender and Over Controller modes were developed in the military to serve the organisation and to do the job expected of him. Ryan's identity still remains enmeshed with being a soldier as he seeks the same purpose, stimulation and value as he did when he was a functioning soldier. These modes play out in his current day-to-day interactions and relationships causing ongoing issues. Understanding the development and implications of these modes and strengthening his Healthy Adult, will require him to finally relinquish the soldier within him, which he is still not ready to do. Hence therapy will continue to challenge these maladaptive modes and further strengthen and develop his individuation as a person and Healthy Adult.

1. Department of Defence, Mental Health in the Australian Defence Force: 2010 ADF Mental Health Prevalence and Wellbeing Study Report, p. xix.

* Name changed to protect identity

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