THE SCHEMA THERAPY BULLETIN

The Official Publication of the International Society of Schema Therapy

This issue- Experiential Elements in Schema Therapy

Schema Therapy relies on Cognitive, Behavioral and Experiential Strategies as well as Limited Reparenting. In this issue we are pleased to highlight some new and creative approaches to Experiential work.

Ofer Peled proposes eight different presentations of dysfunctional parent modes, and has a developed a hierarchy of confrontational interventions to address each presentation. Identifying both the the characteristics and the intensity of each dysfunctional parent mode, and understanding the patients unmet needs enables therapists to assume a stance in imagery or in mode work using chairs that will be most effective in helping patients get core needs met in a healthy way.

Christof Loose works with children and adolescents. His article describes a very creative technique he uses with children, in which he and the child identify the child's modes, and write them down. The child then creates his own "mode sketch", and assigns a finger puppet to each mode. Through the finger puppets the child is able to understand his modes, and work with them to find ways to get his needs met.

Rita Yonan works extensively within a group schema therapy framework. She looks at novel creative and experiential opportunities that are available within group schema therapy context. In addition, she discusses how experiential and emotional components of therapeutic work can be enhanced within a group format.

Chris Hayes is involved in research investigating the use of imagery respiting for childhood trauma. His article discusses imagery re-scripting within schema therapy context, and looks at

In this October Issue

practical ways therapists can improve imagery techniques and skills.

Bruce Stevens and Pierre Cousineau contributed an article about Memory Reconsolidation and the brains ability to unlearn or relearn at the level of Emotional Learning. They describe recent findings which may help to explain why imagery is such a powerful intervention in Schema Therapy.

As these innovative techniques demonstrate, Schema Therapy remains a dynamic and evolving model. We look forward to continue to share our members creativity with you in future issues.

Editors,

Lissa Parsonnet, PhD., LCSW (USA) & Chris Hayes, Clinical Psychologist (Australia)

A Hierarchy of Confrontational Interventions Facing 8 Dysfunctional Parent Modes

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Young et al. (2003) refer to the critical punitive and the demanding parent modes as negative internalized representations of parents and other significant figures. Since there are several parental styles (e.g. Maccoby & Martin, 1983) it is conceivable that there are much more internalized dysfunctional parent modes than

the two suggested by Young.

Young et al. (2003) instruct therapists to help patients battle and defeat their internalized dysfunctional parent modes. Many patients and therapists find combating the parent voices makes them needlessly critical and punitive themselves. The hierarchy of confrontational interventions enables matching the intervention to the severity of the dysfunctional parent mode. As with real parental coaching, when the parent-child relationship is not that devastating, the hierarchy starts with empathic confrontation.

Empathic confrontation (Young et al., 2003) enables therapists to acknowledge the past circumstances that led patients

develop their schemas and coping strategies (the empathic component), while pushing for reality testing, distinguishing past from present and confronting the need for change (the confrontational component). I would emphasize that the empathic component should validate the core emotional needs underlying the schema; the confrontation should address the maladaptive coping behavior. Validation makes patients feel genuinely understood by the therapist and appreciate their core emotional needs and thus more receptive to the confrontational part which helps patients change their behavior to better realize their needs in the preset relationships.

Most parents mean good and try to balance between their children's needs and their own. Validating this attempt allows patients to maintain their link to their formative support structure (e.g. parent, family, community, culture) and meet the core emotional need for connectedness. The confrontational component emphasizes the patients' right to move away from the harmful aspects of the parent mode and seek for getting their emotional needs met more appropriately. The therapist takes proportional action that moves from coaching (in the mild level) to expelling the internalized parent mode (in the extreme level). The hierarchy contains 3 levels of severity and 8 dysfunctional parent modes:

A.Distressing level (for mild degree of severity)

At this level it is quite easy to validate the internal parent's good intentions. Usually the internalized parent lacks the knowledge and skills to appropriately and effectively meet the

child needs. Education about children's developmental needs, and coaching appropriate attitude may prove sufficient

1.The Naïve Parent Mode

Characteristics: This internalized parent is immature, naïve, easily influenced by others, tends to accept people and circumstances as they are. This mode fails to teach right from wrong, anticipate consequences, provide guidelines for handling everyday life situations, and supply sense of safety.

Patient's unmet needs: Protection, guidance, realistic limits

Therapist stance: The therapist can validate the parent's acceptance of the child and their enthusiasm to spend time with the child, as well as feeling puzzled when they need to provide guidance to the child: "I can see how happy you are to spend time with your child until it gets more complicated and then you feel puzzled. Is there someone with enough experience that you can consult with? If there is no one I will be happy to guide you how to meet your child developmental needs".

The therapist can validate the parent's acceptance of the child and their enthusiasm to spend time with the child, as well as feeling puzzled when they need to provide guidance to the child

2.The Anxious Parent Mode

Characteristics: This internalized parent is highly anxious, worries things will go wrong, and overwhelmed with images of bad outcomes. This mode becomes over protective, intrusive, and fails to let the child mode practice some sense of competence and separation.

Patient's unmet needs: Autonomy, competence, sense of identity; spontaneity.

Therapist's stance: The therapist can validate the parent wish for an inner sense of safety regarding the child, while understanding that the child must develop the ability to take good care for him/her self. The therapist can instruct this mode to practice anxiety regulation techniques and guide them to encourage self efficacy and resilience in the child by helping them to take calculated risks and develop problem solving skills: "Of course you care for your

child's safety and yet you want him to become a self reliant adult with full ability to take good care for himself. To achieve this precious goal we, the parents, need to contain our fears, acknowledge them without acting upon them, and bit by bit free our child to experience life and develop some sense of competence. I know that can be difficult. Will you try that for the sake of your child?"

3. The Permissive Parent Mode

Characteristics: This internalized parent is more like a friend of the child. Usually holds a stance that children have to fallow their inner inclination with minimum interruptions from their environment. The parent tends to praise, admire and even aggrandize the child but sets almost no standards of mature behavior, self regulation and discipline, expectations for sustaining immediate gratification for the sake of long term achievements. This mode resembles Baumrind's indulgent parenting style (Baumrind, 1967).

Patient's unmet needs: Realistic limits and self control.

Therapist's stance: The therapist can validate the parent's great joy in watching their child develop authentically, while setting realistic limits: "it is great that you care for your child authenticity in his relations with himself and with others; I can see how much you genuinely love who he is, as he is. But every child needs to learn to regulate their affect and behaviors, and develop the ability to tolerate frustration in order to achieve their long-term goals, effectively communicate with others, and recognize and respect their own inclinations without violating the feelings of others. Self regulation is developed through modeling and teaching from care givers, who need to find a balance between "freedom" and realistic limits. How do you think we can achieve this goal?"

B. Grave level (moderate degree of severity)

At this level it is more difficult to validate the internal parent's good intentions. Usually the internalized parent blames the child for his/her own wishes, or pushes him/her to meet unrelenting standards. The internalized parent lacks empathy for the child's emotions and may become more argumentative or rigid when someone expresses disagreement with them. At this level the therapist is more assertive in providing guidelines for the treatment of the vulnerable child, and may need to set limits to protect the inner child.

4. The victim-like parent mode

Characteristics: This internalized parent believes that others are responsible for his/her bad experiences; feels entitled and demands being taking care of; or uses his/her suffering to keep others emotionally tied to him/her. This parent mode depends on the vulnerable child to feel safe, belong and loved. When the vulnerable child tries to stand for his/her rights the internalized victim-like parent mode turns to accusation, emotional or sick-role behaviors to restore his/her grasp upon the vulnerable child.

ISST News

Schema Therapy TV-

Watch Alp Karaosmanoglu interviewing top schema therapists- these can be viewed at www.schematherapysociety.org/SchemaTV

2018 Conference

The conference shortlist includes

- Washington DC, USA
- Perth, Australia
- Krakow, Poland
- Honolulu, USA
- Barcelona, Spain

The successful city will be announced at the Vienna conference.

Patient's unmet needs: Autonomy; freedom to express valid needs and emotions; authenticity, spontaneity and play.

Therapist's stance: The therapist can acknowledge the internalized parent need for love and care while setting limits and giving instructions allow the child to practice separation individuation according to the developmental tasks: "I can see how hard is for you to see your child grows to be separate human being who may feel, think and wish differently from you. You might be sure it causes all the pain and trouble you have. Your child cares for you but you need to take responsibility for your own well being. I want you to free your child to discover his own inclinations and I will be here to stop you whenever you cross the line by tying your child too close to you".

5.The demanding and critical parent mode (Young et al., 2003)

Characteristics: This internalized mode sets unrelenting expectations and standards in areas such as achievements, moral behaviors, devotion, punctuality, perfectionism, efficiency, pragmatism etc. This mode criticizes by means of verbal, tone of voice, disapprove facial and body expressions and induces sense of guilt, shame and failure in the vulnerable child mode.

Patient's unmet needs: acceptance, competency, spontaneity and play.

Therapist's stance: The therapist can acknowledge the inner parent best intentions for their child, but needs to confront the criticism that crushes the inner child's sense of worth, competence, creativity and wellbeing: "I know you want the best for your child but your criticism crushes your child potential to prosper. I want you to stop criticizing and change your attitude by addressing your child needs for acceptance, competency and creativity. You can start by giving praises, compliments, encouragement for creativity, and embrace mistakes and difficulties."

C.Critical level (extreme degree of severity)

At this level little if any room is left for validating the internal parents' intention. These dysfunctional parent modes cause such profound harm that immediate action is needed to stop and expel them in order to save the vulnerable child mode. Usually these parent modes are internalizations of a very disturbed significant figure that is not capable of taking care of

the inner child. The therapist needs to intervene immediately and engage other authorities such as social services, police etc.

6. The neglecting parent mode

Characteristics: This internalized mode is aloof, disengaged, and practically neglects the child's emotional basic needs and assumes little if any parental responsibility. This parent mode is based on Maccoby & Martin (1983) neglectful parental style.

Patient's unmet needs: The child's emotional needs are not met because the attachment figure is emotionally absent.

Therapist's stance: The therapist needs to confront the neglecting parent mode and engage healthier figures to take care for the vulnerable child. Usually healthy figure needs to step-in and some form of internal foster care arrangement may be considered: "Your child needs to be taken care of by engaged person who will pay attention to the child's emotions and supervise his behaviors. I want you to be engaged as much as you can but in the meanwhile Mr./Mrs. Y will be involved. Don't sabotage this arrangement for the sack of your child. The social services will be involved to help this arrangement work."

The therapist needs to set limits and provide psycho-education about a child's emotional needs for secure attachment, stability, guidance

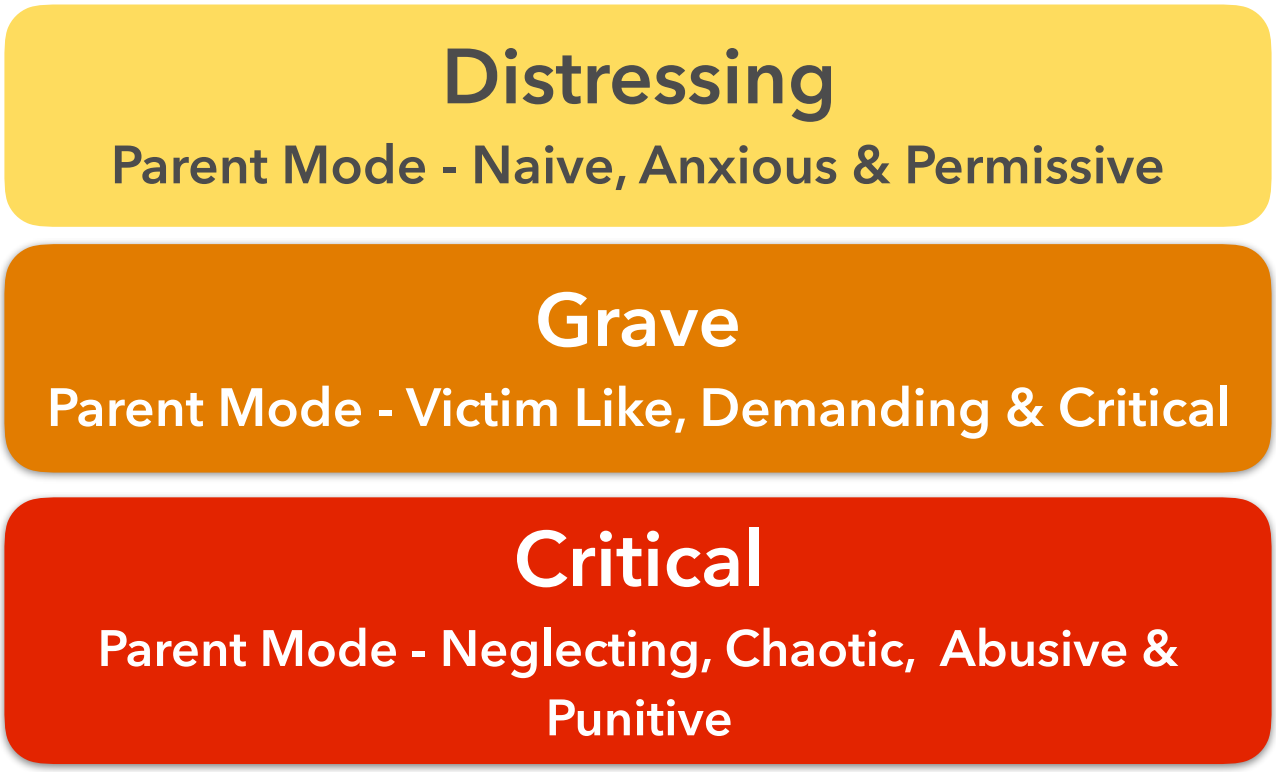
7. The chaotic parent mode

Characteristics: This internalized mode is unstable, unpredictable, disorganized, frantic, and emotionally labile. This mode is so self absorbed in his/her own problems and has no capacity to take into account another person, not even their own child. Living with this person is frightening and paralyzing, and makes the vulnerable child mode constantly alert.

Patient's unmet needs: No emotional needs are met, especially those for secure attachment, realistic limits and self-control.

Therapist's stance: The therapist needs to set limits and provide psycho-education about a child's emotional needs for secure attachment, stability, guidance etc. The therapist limits or minimizes the impact of the chaotic parent mode by engaging healthier figures (such as relatives) to protect and nurture the vulnerable child mode. The social services may need to arrange foster care: "I can see you have a lot on your mind and you are in a great need for help which I'm willing to arrange for you. But right now we have to take good care for little (child)'s need for stability and a sense of security. Mr./Mrs. Y (healthier relative) will take care for little X (child). You may be in contact with your child under the supervision of Mr. Y.

Youneed to put yourself together and take some professional help. The social services will be



part of this program to help you and protect little X".

8. The abusive and punitive parent mode

Characteristics: This internalized mode is the worst form of the dysfunctional parent modes. Almost always this figure is severely mentally disturbed or suffers from severe personality disorder and is not capable of parenthood. This internalized mode humiliates exploits, intimidates, physically/sexually abuses and is very cruel toward the inner child. It is unbearable to live next to this figure. This is an extreme version of Young's punitive parent mode (Young et al., 2003).

Patient's unmet needs: All the emotional needs are unmet but most of all the need for a secure attachment.

Therapist's stance: The therapist needs to stop immediately the harm this abusive mode causes and take the vulnerable child to a secure place. There is no other way than getting help from the social services and the police in order to protect the little child. The therapist can say: "I need you to stop right there what you are doing to little X (the name of the patient). It is wrong and you are not allowed to do this. Obviously you have great troubles and you need professional help that I can arrange. But right now little X cannot stay with you. The social

services and the police are here to protect little X. If little X will need to see you it will be only under supervision of the authorities."

The confrontational hierarchy is a spectrum of interventions tailored according to the internalized dysfunctional parent mode's severity. Matching intervention depends on three axes and the interaction among them: 1. Reality axis – rate of severity and danger in actual relationships; 2. Internalized relationships axis – rate of dysfunctional parent mode's severity (distressing, grave, critical); 3. Therapy stage axis – starting phase may require implied confrontation due to the fragile therapeutic alliance. Gradually the confrontation may become more explicit as the alliance grows stronger. Eventually engaging the healthy adult mode is advisable as it become more prominent in therapy. These interventions, which blend validation and confrontation, empower the healthy adult mode by allowing the patients to rebalance between the need for connectedness and the need for being unique individuals who know how to take good care of themselves. The hierarchy enables the patients to differentiate themselves from the dysfunctional aspects of the parent mode and promote their separation-individuation process.

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Schema Therapy with Children and Adolescents an Extract of Mode Work

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Let's imagine, there is a boy named Felix. His parents notice that something is wrong with him. His teacher says that he tends to be aggressive. They decide that he needs some help. They look for a therapist who can help Felix. Then, Felix gets to know Chris. He is a

psychologist and therapist for children and adolescents. After Felix's parents have asked him to help, he meets up with Felix. Chris encourages Felix to talk about himself and his world. He is especially interested in all the different sides of Felix that come out at different times. He calls these different sides „parts" or „modes". He asks him: Felix, I am really interested in finding out about you, and about all of your different sides, or „modes" as I call them. Which different sides of yourself have you noticed? Let's write that down, okay?" Felix creates his own mode-sketch.

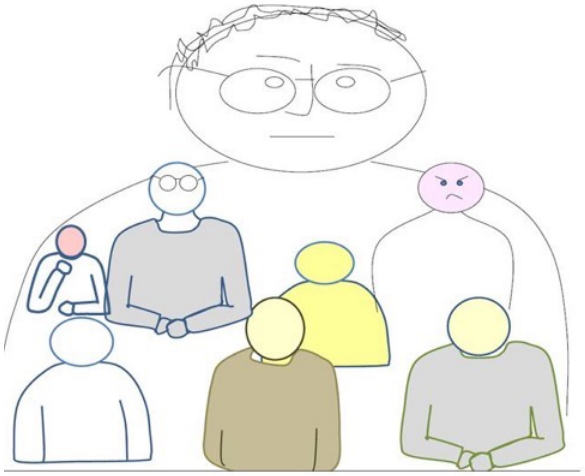

Fig. 1. Felix' modes in a sketch

Once we have a picture of all of the different sides of Felix, he then chooses a finger puppet for each mode.

Fig. 2 Felix shows how he rates the popularity of his modes.

There is one thing that Felix knows for sure: His favourite is the contented mode. And he smiled a lot when telling that. And his least favourite is the sensitive and vulnerable one. Felix looks sad now. But what about the others? Let's have a closer look at them. "Modes, could you introduce yourselves, please?"

Hello! I go first, to get the least favourite over and done with: I'm a part of Felix that many people consider to be too sensitive. As you can see, I'm already pretty scruffy. I don't like that at all, because in fact, I want to be pretty and strong. However, in reality I'm very, very sensitive. A lot of people call me the „vulnerable or hypersensitive Felix".

Hello from me as well! I am the contented, sometimes happy, part of Felix. I come out when Felix feels good, and I look like joyfulness, giggling, and lots of fun and happiness.

Good day! I am another part of Felix. In fact, I am the clever & wise part. I know an answer to everything, and know about Felix's needs or what might help him in difficult situations. I usually look after him well, however sometimes I just don't know what to suggest to him.

Hi! I am the „aggressive“ Felix. Nearly everyone shys away when I come out. I let Felix rage and yell. This often results in some problems... But he feels proud because NO ONE else is as powerful and strong as me.

Hey! I am the imaginative and fanciful part of Felix. When I am there, he is a fountain of fantastic ideas. Well, the others are „louder“ than me for sure and try harder to get his attention, but without me Felix would be SO BORED. And I help him with ideas to solve a lot of his problems, too.

[quiet] Ohhh, I hardly dare to speak. But I'll try... Hello... I am Felix's anxious and scared side. When I come out, Felix usually backs away. He feels insecure and sometimes he also feels ashamed and almost completely loses confidence in himself.

Good day! I am the angry part of Felix, as you can tell from my facial expression. I often come out when others are being unjust, unfair, or mean. I SIMPLY CANNOT STAND PEOPLE BEHAVING LIKE THAT, ESPECIALLY TOWARDS FELIX.

After Felix has talked about his modes and assigned finger puppets to them, Chris comes into play as a miniature figure. First, Chris turns to the scruffy, bedraggled, Raven, the vulnerable Felix, and comforts him, soothing the pain from all the difficult, horrible, times he has experienced. He provides the vulnerable Felix with a big patch and asks him, „what would help you to feel better right now?“ „At last, someone is taking care of me, and noticing all my pain and struggles!“, says the Raven, „First of all, I simply need your attention and comfort.“ The others don't even care about that!“ Chris sticks the patch on the Raven's upper body, like a medal, as he replies, „I would very much like to give you my attention and comfort. I'd also like to help you get to know a bit more about your vulnerability and sensitivity, so I can help you to understand more and even feel a bit better about yourself. Would that be okay with you?“ And, as Felix nods his head, Chris begins to explain to him...

... that his "vulnerability" is actually a special gift. A superpower called the “Super Sensor” that lets him feel what others are thinking and feeling, and also to notice if anything is wrong or unjust. Chris presents Felix with an antenna labelled "Super Sensor" as a sign of this special gift, this superpower.

The vulnerability or sensitivity, which many people have made out to be a bad thing, has now become a (positive) sensitivity, a “Super-Sensor” superpower. This already sounds much better to Felix. And because the “Super-Sensor" has done such a good job and reported all the injustice that took place in the world, Chris gives him an award: The Golden Antenna! He is really proud now!

Fig. 3 Chris presents Felix with "Super Sensor" antenna

However, Felix does not like to brag about things so he decides to take the award off the antenna and place it out of sight. He knows about the award, others don't need to see it, and it is more important to him that the wounds are well protected. Therefore a bandage is

placed over the patch so that everyone remembers that he has already been through a lot of injustice (that's why he looks so scruffy) and – this part is extremely important- that he must be protected by others. Now that the vulnerable and sensitive part is protected, Chris introduces himself to the rest of the mode team. He would like to get to know the other parts better and asks a couple of them to come to the interview podium for a mode interview.

First of all, he learns from the aggressive Felix that he prevents Felix from feeling like a misfit in class. He lets Felix roar and rage, in order to gain more respect from the others. Chris thanks him for his openness and also for trying to gain respect for Felix. However he makes clear that Felix will get into a lot of trouble, and that the respect is not so much respect as fear, and because of the fear, many children will be too scared to get close to Felix. Then Chris talks to the angry Felix, who made friends with the aggressive Felix in order to draw attention to himself. Unlike his parents and teacher, Chris praises the presence of the angry mode. In fact, feelings of anger are a natural reaction to injustice. These are at least partly legitimate. But he also makes it clear that the legitimate anger should make friends with other modes, otherwise Felix - if he only expresses his anger through the aggressive Felix - will always be the one who gets into trouble. Then Chris turns his attention to the anxious and scared Felix, who is scared of looking like a fool in front of the other children and becoming a victim. Chris now focuses on reducing how often the anxious and scared part comes out, while also helping angry Felix to make friends with, and receive support, from the other modes.

Now Chris turns his attention to all the other modes and calls a mode council. It's like an inner family meeting, where all the important things can be discussed openly and safely. The mode council mainly discusses the vulnerable Felix who is "wounded" and in need of protection, and certainly does not deserve to be laughed at or ignored. And it is discussed that the vulnerable Felix has to be acknowledged as a "Super-Sensor", thus as a very important source of information! Without him the other modes would have no idea what kind of injustice is happening in the world out there, and that vulnerable Felix does not want to be the weak and unpopular mode all the time. That's just not fair, because he is doing such

an important job, and doing it so well! And that he needs everyone's help when he has something to say.

Fig. 4: Mode Council

A basic rule is made: There is ALWAYS a reason behind vulnerable Felix appearing (i.e., when the big Felix is hypersensitive, perhaps in class). And in order to figure out the reason, he needs help, especially from the clever & wise mode. The angry and anxious Felixes both add that they sometimes feel left alone, and that is when they ask the aggressive Felix for "support", because he will definitely do something, unlike the others who don't respond at all, or only just a little bit. But this aggressive mode is really just an emergency mode, and needs to be kept only in case of an absolute, complete, dire, catastrophic, emergency!!

The contented, imaginative and especially the clever & wise mode explain to the aggressive mode that they are going to take more care of the vulnerable, fearful and angry modes, and they apologize for having neglected the vulnerable, fearful and angry modes in the past. Then all the modes come together, led by clever and contented modes, who celebrate the importance of the vulnerable and sensitive mode. Everyone agrees that the raven can wear the Golden Antenna with pride and celebrate his achievements! And after a long, long time the vulnerable Felix finally feels that everything is okay with him. That he is not a pushover, loser or hypersensitive person.

But he also understands now that he must learn to ask the others for help when he experiences injustice in the world outside. Thus all the modes can come together as friends, as a team led by the clever and wise mode, and all together can help to do something about injustices.

Experiential Strategies in Group Schema Therapy

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When I was asked to write this paper on "how to do experiential strategies in group" it got me thinking – what is different about implementing Schema Therapy experiential interventions in a group versus individual? This is something I do day to day, (for the last four years in fact) as part of my role as the Program Director of a Group Schema Therapy Program at a private psychiatric hospital in Melbourne, Australia (The Victoria Clinic). Although GST is theoretically consistent with individual ST and most individual interventions can be adapted to use in groups, a group does offer some additional creative opportunities. GST strategically uses the therapeutic factors of the group modality as described by Yalom. We also know from the Farrell, Shaw & Webber (2009) rct and the published pilot done in the Netherlands (Dickhaut & Arntz, 2014) that a group seems to catalyse the therapeutic effects of ST for patients with BPD. For this article, I discussed the issue with Joan Farrell and Ida Shaw, the developers of Group Schema Therapy for Borderline Personality Disorder and the creative minds behind the imaginative ways in delivering emotion focused techniques within the group setting.

The advantage of doing emotion focused work within a group setting is that affect can be amplified by the presence of more people in the therapy space. Similarly to individual ST, emotional material can be explored and used as a

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
- 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

learning tool for the root experiences associated with a patient's schema modes with the advantage of the opportunity for group members to learn from each other and from others experiences. Trauma processing work, like imagery re-scripting, can be conducted in groups as well and group members can add a different kind of support than therapists. Sometimes just observing other group members doing emotion-focused techniques triggers emotional responses that reach the Vulnerable Child mode of observing members. Vicarious learning is a group opportunity for patients with avoidant features. In order to keep this brief I have focused on a few techniques that give a snapshot of Experiential Strategies in GST. For a more detailed read please refer to *Group Schema Therapy for Borderline Personality Disorder,* Farrell, J.M. & Shaw, I.A. (2012) and Farrell, J.M., Reiss, N., & Shaw, I.A. *The Schema Therapy Clinicians Guide: A complete Resource for Building and Delivering Individual, Group and Integrated Schema Mode Treatment Programs.*

Below are a few interventions that one could use within a group format as per Group Schema Therapy (GST) with Borderline Personality Disorder (BPD) protocol by Farrell & Shaw (1994).

The Art of Story Telling

Imagery work is a powerful experiential intervention used in Schema Therapy for healing the Vulnerable Child Mode. In GST imagery change work or rescripting can be delivered in two main ways: individual rescripting with group involvement and group as a whole rescripting. Needless to say it is crucial to establish safety before doing any imagery work with patients who present with a history of trauma and neglect. For patients with BPD connecting with their Vulnerable Child Mode is usually met with negative and rejecting feelings. Therapeutic stories of little children in situations where they have needs are often used to assist patients in having compassion for a child's emotional needs. This slowly paves the way for patients to consider how helpless children can be and how dependent they are on a good parent to have core needs met including feeling safe, secure and predictable. Through the story patients are encouraged to think about what messages the child in the story would have taken from the experience about her self-worth and the normality of needs being met by the adults in her world. Patients are then encouraged to think about their Vulnerable Child and their needs in

the same way to transfer compassion for stranger children to themselves. Here's an example:

The advantage of doing emotion focused work within a group setting is that affect can be amplified by the presence of more people in the therapy space.

Alla & The Thunderstorm

"A little child four years of age, woke from the crackling and banging sounds and loud rumblings of a thunderclap that was so loud she felt like it was shaking her bed. The noises were followed by bright flashes of lightening that left behind scary images on her walls. At the very next thunderclap she flew from her bed and ran to her parent's room feeling so frightened that all she could do was shake and cry. Her crying turned into a scream at the next sound of thunder. Her parent woke and started to yell at her, stop crying they said: "It's just a thunderstorm, stop being such a big baby. Go back to bed before you wake the entire household." She went back to her room but couldn't stop crying. She bit down on her blanket so no sound would escape. She tried covering her ears so she wouldn't jump at the thunder, and she closed her eyes to stop seeing the scary arm that were reaching out to grab her from the walls. She bit down harder and kept her eyes closed, blocked her ears and kept repeating this over and over. After a while she didn't jump anymore, even though the thunder was louder, nor did she shake and duck when the creepy arms tried to get her. She just sat there staring off into space."

This story provides an example of the kind of situations in childhood where needs were not met and schemas and modes develop. It does not need to be a situation of abuse, rather a time when a child was left on his or her own to deal with intense feelings before he/she had the resources to do so. In such situations a version of fight, flight or freeze will occur. One of the most common child responses in the thunderstorm story is Detached Protector. Another possible response would be Angry Child. The use of stories however, really encourages a discussion around children and needs in a safe way for participants, and encourages self-disclosure.

The importance of the happy-joyful child

The importance of spontaneity and play in child development has been well documented as well as the importance of evoking and strengthening the Happy or Contented Child Mode (summarized in Lockwood & Shaw, 2012). Play and creativity facilitate healthy emotional development and provide the earliest learning about social interactions. In the case of patients with BPD spontaneity and play were invariably not met, and not present in their family environments. Through play when adult schema's like Emotional Inhibition can be

targeted as well as Mistrust/ Abuse and Social isolation/ alienation. Imagery involving play can be a safe way to initially engage patients who have a strong Mistrust/Abuse schema and/or are unable to connect with their Vulnerable Child Mode.

In GST Happy Child imagery is often used to evoke, joyful feelings and as a balance to the difficult and painful work of healing the VCM. An imagery exercise that we use in group is "the visit to the toy shop" (Shaw, 2010). In this image patients are encouraged to get an image of their little selves, with the other group members standing at a bus station waiting for a bus to arrive to take them to a surprise outing. The five senses are used as in traditional imagery to fully engage them in the experience. Patients are instructed to notice what it feels like travelling in the bus, the view from the window, the songs they sing together whilst they eagerly await arrival to designated destination point. Once they arrive they are told that they can see out the window where we have come to; a toy store so big that there are sooo many different toys in there that they are going to be given time to search through the entire building. They are also told that the group facilitator has won the lotto and they can buy ANYTHING they want from the toy store. The participants are talked through the different aisles they encounter and can access. Reference is made to their group peers and how they look, act and behave in the toy store. The image is brought to life as much as possible. When the imagery exercise is complete, patients open their eyes and are asked to describe their experience and what toys they selected. As a facilitator whether you are the observing therapist or the one telling the story, it is a delight to see the patients faces light up as they are truly involved and lost in the image, some laugh out aloud, others are smiling, others have a concentrated look as they are trying to locate that "right toy".

The use of Happy Child Imagery is also a good way to deal with a group that is stuck or in need of a shift in affect. This must be done with a significant amount of enthusiasm, and

some therapists who have their own Emotional Inhibition Schema may struggle with this exercise. Ida Shaw has a contagious and exuberant way of delivering this imagery; in her training one can really get lost too in the joy of the exercise.

Healthy Adult Representation – Group Based Transitional Object

An unstable identitfile:///Users/chrishayes/Downloads/treey is a core symptom of patients who present with BPD. Individuation and identity formation is the latter phase of the GST process. The close analogue to the adolescent "peer group" these patients missed and, provides a healing role in this unfinished stage of identity formation. An example of a creative experiential group exercise that targets the Defectiveness/Shame schema found in many BPD patients and to strengthen the Healthy Adult file:///Users/chrishayes/Downloads/treeMode is the group multi-bead bracelet.

In a group session, therapists provide patients with a selection of inexpensive beads and group members and therapists select a bead for each member that represents a personal characteristic of him or her that they like or value. The "identity bracelet" for each person is built by group members taking turns to presenting a bead and making a statement about what it represents. This process continues until all patients have a completed bracelet. A visualisation exercise follows in which patients are instructed to connect with the positive feelings of receiving the bracelet in imagery while wearing the bracelet and putting their hand over it. In this way the bracelet can be a physical anchor upon which to build a more stable positive identity supported by their positive peer group. Beads can be added over the life of the group to represent important experiences like a moment of belonging in their VCMs.

This activity is likened to the behaviour seen in adolescents who often trade pieces of jewellery or clothes with best friends as part of bonding and identification process that underlines identity formation. This emotional learning experience was usually one missed for patients with BPD who grow up in invalidating or abusive childhood environments without a sense of belonging to a healthy peer group or any group at all.

"The Group Army"- Fighting the Punitive/Demanding Critic Mode

Recent Schema Releases and Research

"Fine Tuning Imagery Re scripting". Remo Van Der Wijngaart & Chris Hayes , 35 video, 3DVD set focusing on imagery rescripting (available at www.schematherapytraining.com www.schematherapy.nl)

Thiel, Nicola, et al. "Schema therapy augmented exposure and response prevention in patients with obsessive-compulsive disorder: Feasibility and efficacy of a pilot study." Journal of behavior therapy and experimental psychiatry 52 (2016): 59-67.

Porter, R. J., et al. "No change in neuropsychological dysfunction or emotional processing during treatment of major depression with cognitive-behaviour therapy or schema therapy." Psychological medicine 46.02 (2016): 393-404.

Thiel, Nicola, et al. "Schema therapy augmented exposure and response prevention in patients with obsessive-compulsive disorder: Feasibility and efficacy of a pilot study." Journal of behavior therapy and experimental psychiatry 52 (2016): 59-67.

Imagery work in which the group and therapists become a "protective army" can be developed to support a patient in banishing their Punitive Parent. One powerful exercise is building a parent or critic figure out of cloth that patients can draw in whatever way they want and then write their critic messages on. This figure can be placed in a chair to concretely represent their Critic Mode, lending reality to mode dialogues and evoking strong emotions, including fear, anger and rejection. The parent "effigy" can be locked away by the therapists to underline its powerlessness to do harm in the present day. Joan Farrell has a favourite demonstration of the power of the Punitive Parent being an illusion. She holds the effigy up and compares it to the well-known movie character the Wizard of Oz. She suggests that like the Wizard, the Punitive Parent is an illusion, a screen that hides a powerless character. She holds the figure up to full height and then lets it drop into a pile on the ground stating, "like the Wizard, the Punitive Parent is all smoke and mirrors". After completing this exercise, just like experiential work in individual schema therapy, patients always comment on the power of the exercise, despite their preconceived ideas, and invariably turn to their fellow group members and offer their appreciation of them joining the fight against their Punitive Critic Mode.

Imagery Rescripting- The power of the Group

Healing the Vulnerable Child in Imagery can be done in a number of ways in GST: a) historical rescripting (e.g. trauma) b) using the cue for the group as a whole of a time when they needed a good parent c) Getting an Image of their VC and hearing Good Parent messages spoken by the Therapist d) through story telling as previously described or e) through the use of an Affect Bridge

Joan and Ida recommend that therapists set the stage for trauma rescripting in group by giving a demonstration in which the group with the second therapist rescript a medium level of difficulty memory of the other therapist. The approach is that the therapist tells about a memory as a child of an experience in which a good parent is needed and no one is there. After this the group discusses what the therapist as a child needed, what his/her feelings were and

how the needs could be met. The rescript developed by the group members is checked out with the therapist presenting the memory and additions or subtractions are made. The other therapist then instructs the group with him/her to close their eyes connect with their VCM and listen to what is said as a good parent to the therapist with the memory. They are told to try to take in the positive reparenting messages and listen to the therapist's tone. At the end the group discusses how this went and the effects. The therapist sharing the memory describes the new message she can take away from the rescripted experience. The group s then asked who among them has a similar level of difficulty memory they would like the group to rescript. Over time the group can also be involved in the implementation of the rescripted memory. They may join a lonely child on the school playground or help rescue a child from abusers. This use of selective self-disclosure from the therapist strongly facilitates patients being willing to rescript their memories. It shows them that IMRS is not as scary as they thought and that they do not need to re-experience trauma, rather stop before the trauma actually happened and experience a rescue or what should have happened. The therapist rescript also provides the corrective emotional experience of being treated as if they have worth and value, i.e. they can contribute something to the therapist.

I'd like to thank Joan and Ida for their training, supervision and help in program development in GST and their input for this tiny window into the wonders of delivering Experiential Strategies in a Group Setting.

Memory Reconsolidation: Can we Unlearn Emotional Learning?

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In over 25 (Bruce) and 40 (Pierre) years of being therapists, we have sat for countless hours with patients who have struggled with accepted 'truths' about themselves, beliefs that have governed their lives, limited their choices and flooded their relationships with ugly emotions. We have agonized with our patients in the slowness of the change process.

One of the most important questions in therapy is how can the brain *unlearn* something? Think of one of your patients with early abuse or neglect. Or trauma. Or low self-esteem. Or dysfunctional relational patterns. This is often the focus of therapeutic efforts and it is frustrating how much the brain resists any change, even of early learning which is inherently irrational and completely dysfunctional. And it can last a lifetime driving dysfunctional patterns of behaviour.

Emotional Learning (EL) is something like a 'bad tenant'. The person pays no rent and keeps trashing your house. You want to evict them but nothing works. Even when you hand them a

legal notice it is ignored. You bring in the bailiffs but there is some obscure law they can appeal. Nothing works and the tenant remains.

Martin believed "I am un-loveable" from experiences of neglect as a child. What he missed out on continued and this belief about himself became *consolidated.* For many years it was believed that once learnt, such beliefs were indelible, 'written' in the brain in a way that it could not be erased (e.g., van der Kolk, 1994). Or that the process of change was to learn new habits over the old established patterns. This has been called 'counter-active learning' (Ticic, et al., 2015). This is an attempt to suppress the old learning and to allow a different behaviour, but the old remains and tries to resist. In this view our brain (specifically the limbic system) is a kind of psychological prison.

We will call this approach 'old therapy', like Bruce's children used to say 'old school', and unfortunately most current therapies are counter-active. The counter-active techniques include relaxation strategies superimposed on anxiety, new behaviours to overcome a sluggish lack of motivation and thought blocking to oppose negative thinking. It is like trying to evict the unwanted tenant by wearing down their resistance to leaving.

But what needs to happen to effect real and lasting change? Change must happen at the level of Emotional Learning.

A Scientific Advance

Now some welcome news. There has been some remarkable, if somewhat obscure, research in memory reconsolidation. Memory *consolidation* is when something is learned and later strengthened; memory *reconsolidation* is when something new is learnt in place of what was previously learned. Obviously both are central to the concept of Emotional Learning.

In the following discussion of theory and research I have cited some relevant studies so that you can look at the neuroscientific evidence. It is hard to follow, but worth the effort.

This memory research found that once an emotionally charged memory was formed, certain later circumstances provide an opportunity for change (Pedreira, et al., 2002). The surprising discovery was that the brain is able to wipe-out and change an established belief (Pedreira, et al., 2004). This research was initially done with animals, such as the sand crabs used by Pedreira, but it demonstrated an important neurological mechanism in which an animal can unlearn something and re-learn it (Perez-Cuesta & Maldonado, 2009). The stimulus with the sand crabs was of a predator (Pedreira, et al. 2004) which produced a trauma-like response – which could be unlearned and safety re-learned. A similar mechanism has been found in human memory research (Forcato, et al., 2007). The process of memory formation (consolidation), retrieval and re-consolidation has now been well described and it would appear that a number of different types of reactivation, such as waking reactivation (Walker et al., 2003), can lead to reconsolidation (Alberini & LeDoux, 2013; also Lattal & Wood, 2013). An interesting by product of this line of inquiry is how to match certain drugs to gain a similar effect (discussed in Alberini & LeDoux, 2013). This could have important implications for the practice of psychiatry. Nader & Einarsson (2010) have provided a useful review.

If you are interested in a thorough review of fundamental research in memory reconsolidation, we recommend the textbook edited by Alberini (Alberini, 2013). Also, Bruce Ecker (2015) wrote an important paper on the specifics of memory reconsolidation process.

About Therapy

All this has revolutionary implications for therapy. Bruce Ecker has incorporated principles of memory reconsolidation into his Coherence Therapy, the "reactivation of a well-consolidated, longstanding implicit memory appeared to have rendered the stored emotional learning susceptible to dissolution." (Ecker, 2012, p. 18; also Ticic, et al., 2015). What came to be appreciated was that a reactivation can de-consolidate a memory into a flexible state, which was temporary and could be followed by a relocking or reconsolidation with new learning if some mismatching information was present. The new 'over-writes' the old. Arntz mentioned memory reconsolidation in his key note address at Istanbul, 2014.

New learning is supported by realization or direct perception. This gives an understanding of the reasons why visualization techniques could be so efficient in Schema Therapy. We suspect that memory reconsolidation, as a mechanism, operates not only in ST but in a range of experimental therapies such as Coherence Therapy, EMDR, Emotion Focused Therapy, and possibly psychoanalysis in its various forms. This is why such transformational therapies 'work', though not all practitioners are aware of the neuroscience mechanism of memory reconsolidation.

At the risk of overstating a claim, memory reconsolidation is the 'holy grail' of psychotherapy. Of course there will need to be future research to establish or contradict this explanation of effective therapeutic change. But few would deny its considerable potential or applicability to the most intransient of therapeutic problems.

Now to some practical steps:

Miss-match

Reconsolidation is highly selective and affects only the memory that is being mismatched, whatever that memory might be. This appears to be an inbuilt mechanism to allow flexibility and change in learning. The change mechanism requires both:

(a) Reactivation, and

(b) Mismatch (an experience that mismatches the target memory or what EL expects).

This "prediction error" is at odds with what is expected. This is what sets off a different mental process which leads to what is best described as transformational change. It replaces old learning. Completely. There is nothing to remain in competition with the old learning (Ticic, et al., 2015).

Coherence Therapy has identified *juxtaposition* of the old and the new learning as elemental for change. A lot is claimed about the effects of such an experience: New learning deletes old learning, is not subject to relapse, remaining symptom free is effortless, and there is an increased sense of a unified self. We can also see juxtaposition in chair-work and rescripting in ST.

Extended Case 1 Example of Sally (Bruce)

The following case is used with permission. I have found that the discovery of EL and juxtaposition works well in therapy, though I would hasten to add that this was a dramatic example of it working.

Sally is a senior military officer. She is highly respected in her field and had responsibility for hundreds of soldiers in a training camp. She thought that her life was "travelling well. I had what I thought was a loving husband, two teenage children and some very close friends. I also had a range of people I knew through a family movie club I attended with my children."

In a few months things deteriorated. Her husband announced he was leaving her. He had been in an affair, which shocked her, and he went to live with his new partner. Sally survived all this but about six months later her three closest friends, for a variety of reasons, ended their friendship with her. One started to gossip about her at church, another moved to another city to

pursue graduate studies and the last became over-involved in romantic relationship. The new relationship took precedence and the girlfriend objected to his friendship with Sally.

All this devastated Sally. She became acutely suicidal and had to be admitted to a psychiatric facility. She was seeing a counsellor who did some good work on Sally's grief, but became worried about the suicidal crisis. I saw Sally at that point and worked closely with her family doctor and a psychiatrist who prescribed anti-depressant medication.

Over the next year I saw Sally more or less weekly. Some of my graduate students were also involved in counselling support. She made great progress. She was able to return to her military duties through a variety of psychological interventions including exposure therapy. She seemed like she was almost fully recovered and we were thinking about completing therapy. But then I thought about how intensely suicidal she had been. It was as if she held her life 'lightly'. Almost with no value. I worried that a similar crisis might occur in the future and then she would be highly at risk of suicide. It had been a 'close thing'.

So I used sentence completion about why she felt she had to kill herself. I had the sentence completion "I need to kill myself because …" The result was very surprising:

> *"I am of value only to the degree I am helpful to others. If I need others, I become a burden. My overall worth is the balance, if it is negative then I should kill myself to restore the balance to zero."*

I wrote this on a card and she said that every word resonated as true for her. She was asked to read the card once a day for the next week. A week later she reported a huge shift. She said that the first sentence "I am of value only to the degree I am helpful to others" felt about 40% true but the rest "not at all true" and was rated 0% true. She saw that previously her sense of self-worth was extrinsic and was shifting to be intrinsic, and she felt "freer". She revised her emotional learning to the following statement, "I am a valuable person because I have my own values which I can satisfy without needing affirmation from others. I can make a valuable contribution without needing it recognized."

I had Sally visualize saying this to a crowd that included her ex-husband, children, parents and siblings. She had made some new supportive relationships and they were included as well. I asked if anyone was missing and she said, "I want to see me there too." She added, "I need to hear myself say it." I could see a profound shift and I was finally satisfied that the risk of suicide was in the past. Her recovery from risk of suicide was as complete. Indeed I have seen her in follow-up sessions since this turbulent period and while she has faced challenges, she is emotionally stable.

Extended Case 2 Example of Martine (Pierre)

The following case is used with permission. Martine was already known to the therapist. The reason for this new consultation was her ambivalence towards a love relationship and her mother's opposition to it (she disliked the boyfriend).

In one session, Martine expressed her wish to go out for a weekend with her boyfriend, but at the same time was literally terrified to inform her mother about it. After this intense fear was

clarified, the therapist asked her to close her eyes, visualize herself informing her mother, focus on her somatic sensations while doing so, ending up by an affective bridge to past experiences with such sensations (discovery work). The patient retrieved childhood memories of physical assaults from her mother. This led us to the following formulation of a fundamental emotional learning (punitive parent - abuse).

> "*Mom, when you're angry at me, I'm afraid that you'll grab me by the throat to kill me, I'm terrified of dying. I become a little defenceless girl. That is what is triggered in me whenever someone is angry with me or demands something from me*."

The daily reading of this emotional belief which was written on a card (integrative work) triggered mismatching experiences (error detection under spontaneous mind processing). Two situations confirmed an emotional memory modification: Martine didn't experience fear when she informed her mother of her plan of the weekend, and subsequently discarded her mother's objection to her personal decision. Martine was astonished that this was done without extensive effort, a complete turnaround from her historical reactions.

But a few weeks later, Martine reported fear again while anticipating another situation. She wanted to stop one of her voluntary work commitments. She had many such commitments and had a hard time saying no to new solicitations (self-sacrifice schema) — this had led her to burnout in the past. But the anticipation of saying to collaborators that she would conclude this specific commitment triggered a fear anticipation. The intensity of this fear was close to terror and it told us that our previous work left another memory track untouched. Metaphorically, work with memory reconsolidation is like a laser beam intervention, you have to make sure you are on the right memory track in order to modify it.

So, we extended our discovery work to this anticipated situation and ended up with the following emotional belief, which added a subtle nuance to the previous one:

> "*Mom, you're too strong for me. When you squeeze my arms, grab me by the throat and threaten to kill me, I can't do anything. If I try to defend myself, you will kill me*."

Spontaneously, Martine came out with a mismatching belief (another emotional belief—not a cognitive disputation):

> "*Today, it is no longer true that I can't do anything. I would be able to defend myself and stop you from killing me*."

This second emotional belief referred to a situation in which, as an adult, she prevented her mother from grabbing her by the throat. We then asked her to read alternatively both emotional beliefs and check out how much they felt true to her (juxtaposition phase). She reported that after a few days, the first one didn't feel true to her anymore. Moreover, the fact that she didn't experience terror or fear with anticipation or actual announcement of her decision to end her voluntary work with the group, confirmed the emotional memory modification. This was done in just a few sessions and the new emotional belief maintained itself effortlessly.

Conclusion

The quest to find what works in therapy has has drawn both of us to the edges of therapy. The needs of our patients have kept us unsatisfied with our answers. Of course we have to preference evidence based therapy, but we would never advance to new EBTs unless we are at some level dissatisfied. So in this brief paper we have presented a process for therapeutic change using memory reconsolidation from the neurosciences. There are a lot of edges but thankfully we do not live on a 'flat world' so we will not fall off if we go there!

Imagery Rescripting: Practical Ways to Improve Skills

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"How about we do some imagery work today?", I said to my client, expecting a predictable imagery rescript where I enter the image, stick up and protect the child, and provide the safety that they had long been deprived. My supervisor at the time had been encouraging me to "do more experiential work". It had worked well in other clients and I was up for the challenge.

"Close your eyes and get an image of you as a child when you felt unsafe", I said to my client. My client replied, "I'm walking into my house, I'm about 5, and as I walk in there are five big bikers who are drunk sitting in my lounge room.... I'm scared".

Taken by surprise, I go through the imagery process trying my best to look calm and collected, but secretly thinking...."WHAT ON EARTH AM I GOING TO DO

WITH FIVE BIKERS?!". I looked around the room as if I was looking for an invisible guiding colleague to appear!

In my mind I have an image of me saying: "Hello chaps.... I'm wondering if you can get out of here, this child is afraid of you... I have a university degree you know!!"

Thankfully, over the years I've been able to continue to develop my skills using imagery rescripting....

Imagery rescripting is a powerful experiential technique that uses the power of imagination and visualisation to identify and change meaningful and traumatic experiences in the past, resulting in transformation in the present. Typically those who are developing skills in schema therapy specifically find imagery work an exciting, but often daunting clinical option. Accessing corrective emotional experiences that a client has often never experienced (such as XXXX) is often a powerful intervention. However, imagery rescripting is an intervention often postponed or deferred in favour of more "safer" options.

In this article, I hope to provide five practical ideas to help fine tune and develop imagery work within Schema Therapy.

1) Imagery Rescripting: "Messing with Meaning"

It is important to understand the theoretical underpinnings that may explain the process of imagery work. At a schema level, Arntz (2015a) notes there are five main functions to the imagery process, 1) the client has an opportunity to emotionally process emotions that typically may not be easily accessed, 2) care, nurturance and support is provided to the client in a way that was blocked as a child, 3) factors that have influenced how they feel about themselves can be externally reattributed (e.g. "It's not that I was a bad child, my parents had serious limitations in their parenting," 4) meaning is changed at a "child level" (one that is not "rational" and logical), and 5) the client is able to understand that their environment growing up was the exception and not the norm.

In terms of traumatic memories, from a cognitive-behavioural perspective, Arntz (2015b) describes how imagery offers a chance to change the meaning of difficult memories through a processing of "unconditioned stimuli revaluation." Here, new information and perspectives are made available via the client having their needs met via fantasy, resulting in a change of the meaning of the memory to the client. The techniques here are not based on systematic desensitisation principals, and as a result therapists should note that they don't need to "play through" the entirety of difficult, in some cases traumatic, events.

2) Increase Attunement in Float Backs to Assist with Better Links

Linking current triggering events to key childhood images can be accessed via a "float-back" or "affect bridge" process. Here, the therapist asks the client to access a current triggering image, identifies feelings and thoughts from this experience, and then links this back to a childhood event with similar sentiments.

Affect and meaning are the longitude and latitude for effective targeted float-backs. Clients can often initially note that they feel "bad", "overwhelmed", and "not good". Here the therapist needs to increase attunement, and really "get" the experience, meaning, and themes for the client.

If the therapist takes as face value the described "bad" feeling ("so hold on to that bad feeling and get a bad feeling as a child"), clients can access a number of "bad" childhood experiences. Greater attunement allows for clearer links to past events. For example, "So is that bad feeling like you don't matter, like you're overlooked, and no one is interested?" "Hold on to that feeling and the sense that you don't matter and get a childhood image where you felt the same".

3) Accessing Specific Images & Memories

It's difficult for anyone to specifically recall meaningful events from childhood, yet alone prize open the memory vault to access memories linked to schemas and modes within a float back context. One method is to use the "Google images" technique (De Jongh, Broeke & Meijer (2010), often used in an Eye Movement Desensitisation & Reprocessing EMDR context.

Here, the therapist suggests to the client that they are making a memory "search" into their mental "search engine" for a particular belief or schema, e.g. "I'm worthless, bad" (aka defectiveness).

Similar to internet search engines, clients are encouraged to suggest several memories that may be a part of their "search," with the top "posting" most linked to the desired search. The therapist may encourage the client to complete such a task in his or her own time as a homework assignment, and use the exercise to "prime" the imagery work, or make links throughout the session. Such key memories can then be used for future imagery work.

3) Winning the Exchange in Imagery

In imagery, the use of fantasy can be especially useful if the therapist feels unable to provide the corrective emotional experience alone. In imagery, fantasy is limitless, so there is always something that can assist with a successful rescript. However, therapists need to be attuned to the client to determine if the intervention is meaningful and corrective. The client initially needs to have some sense of safety, allowing clients to construct an image that allows for safety (such as having a glass wall between the client and the antagonist, or having the client as a child stand behind the antagonist).

In order to create a sense of empowerment and strength, protective devices such as Tasers, Pepper Spray (Mace), or in some cases weapons could be used (particularly with violent antagonists). The therapist can also manipulate the size and form of the therapist (make me 9-foot tall), or the antagonist (make him smaller in size and put him in a glass box).

4) Recollecting, Not Experiencing

Imagery Rescripting- Themes and Responses

Empowerment
-"I am / we are running things now.. not you"*
- "I'm not going to let you do that...."*
-"I'm not afraid of you..." "I can handle you fine"*
"You're going to have to deal with me now..."

Safety
-"I'm here to protect you little X"
-"I'm not going to let you harm her anymore"*

Reattribution
-"What is wrong with you?... what you are doing/ saying is wrong"*
-"She doesn't deserve this..."*
- "I know I am right...." "You're the problem"*
- "What can a 5 year old do that's that bad to be treated this way?"

Care and Compassion
"You're very important/ visible to me" (to child)
-"She/he needs you to hear them, take them seriously...." *
- "You need to show that you care about your kids" *
- "Every child needs to feel like they matter.."

Validation and Grief
-"It's understandable all kids want to feel cared for"
-"Of course you want dad to be nice to you"

*(to antagonist)
Figure 1

Clients can typically "recall" and retell events from the past when discussing childhood memories. However, it is important to help clients move from a "recollection" of an event to an "experience". In some occasions it may be a way for a client to "distance" themselves from emotive aspects of a story (however some clients may be more accustomed to speaking in this way). In this case, the therapist can focus on sensory aspects, and aim to assist the client to speak in a visual and "present" way (preferably in first person, present tense). For example, moving a sentiment from "she was a small girl scared of dad yelling" to "I'm looking at dad yelling and I'm scared." Here the the client is able to take the childhood experience and view the experience from the child perspective, rather than a historical or adult one.

4) Key themes in Rescripting childhood trauma

Whilst not empirically validated, there are several key themes that are often observed in rescripting childhood trauma images and managing antagonists.

Empowerment & guidance: Standing up to antagonists and providing emotional strength.

Safety: Providing protection from antagonists.

Reattribution: Increase perspective and to place cause to external figures.

Compassion & Care: Providing nurturance, care via limited reparenting.

Validation & Grief: Validating experiences and supporting sadness and grief, as a result of not having childhood needs met.

It's important for the therapist to keep in mind what is the corrective emotional experience required in the imagery scene. For example, a client that feels subjugated, dominated, and disempowered in an image may initially need a sense of empowerment and safety. If the therapist enters the image focusing on reattribution towards the antagonist ("What's wrong with you?, you're the problem"), this may not provide the key ingredients for a corrective experience. It may be pertinent for therapists to have in mind, "what does the client need?" and "what is the corrective emotion experience that I'm trying to provide for the client?". Such awareness will act like a compass for rescripting work, resulting in attuned responses.

Often when tackling antagonists, it can be challenging for therapists to initiate effective responses to both antagonists and clients. Figure 1, notes possible responses based on rescripting themes.

5) The "Window of Tolerance" in Imagery

A number of theorists have previously discussed the use of the "Window of Tolerance" when working with affect (Segal, 1999, Ogden 2006). Here, similar concepts apply to imagery-based interventions. There is an optimal "window" of affective arousal that allows for effective imagery rescripting and processing. If there is not enough emotional arousal (Hypo-aroused), the client can present flat, detached, and disconnected from the visual material. Here the therapist may need to focus on working on coping modes that are obstructing imagery work. In addition, the therapist may need to increase sensory aspects to the rescript. One practical tip here is to close your own eyes in imagery work. If you are unable to create an image, then further sensory details may need to be sought.

In contrast, if the client is overwhelmed (or hyper-aroused), the therapist can help the client to use the image itself to "down regulate" affect. For example, the therapist can ask for the image to be "paused" or "to rewind," or for the therapist to enter the scene ("I'm there with you, can you see me, I'm here to protect you"). Hence using the imagery itself as an affect regulation tool (rather than asking the client to open their eyes, etc.).

And so, back to our initial circumstance with the bikers and my client, what happened next.... I asked the frightened child client, "What do you need right now?". She replied, "I need someone to protect me and get these bikers out of my house."

I entered the image, made myself larger, brought along a Taser, a can of pepper spray, and an elite police team dressed in body amour and police dogs...

Despite my own imagined incapacity to "take on bikers" and protect the child, my client noted, "this was the first time I ever felt someone could stand up to them...." A good result...

Fine Tuning Imagery Re scripting- a new DVD set from Remo Van Der Wijngaart and Chris Hayes (available at www.schematherapytraining.com and www.schematherapy.nl)

Announcement- 2016 International Society of Schema Therapy ConferenceVienna, Austria

The ISST board is very pleased to announce the 2016 conference to be held in Vienna, Austria on June 30 - July 2 2015 at the Messe Wien Exhibition & Congress Centre.

The conference will be the focal point of of schema therapy practice and research and will host a number of key note speakers from around the world.

Details and registration details will be available soon at http://www.schematherapysociety.org

Schema Therapy Bulletin- Upcoming Editions

In the next issue we will be bringing you then best from Vienna's ISST conference!

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Imagery Rescripting; Practical Ways to Improve Skills

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