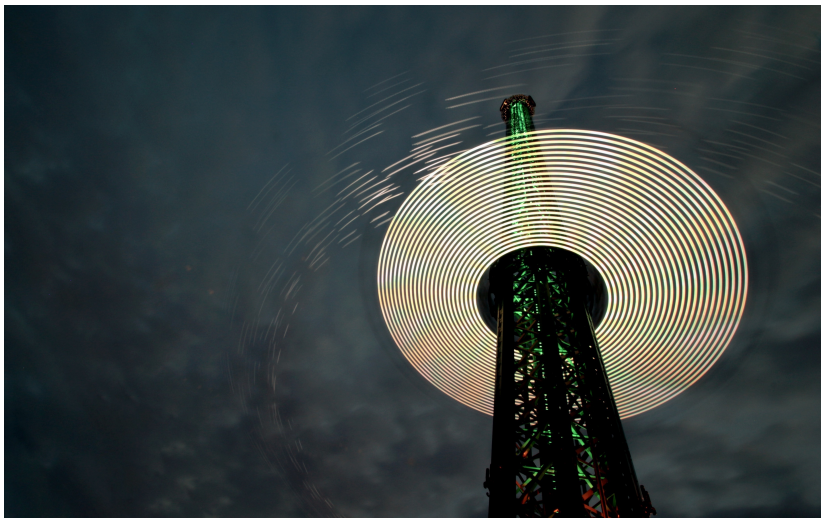
THE SCHEMA THERAPY BULLETIN

The Official Publication of the International Society of Schema Therapy



We are delighted to bring you the 6th issue of The Schema Therapy Bulletin.

Vienna was eight months ago, but no doubt many of you can close your eyes and remember the sights, sounds, smells and flavors of Schnitzel, Gustav Klimt, Strudel, Sigmund, Beer Garten, The 3rd Man, Kaffeehause and the ISST Inspire 2016 Conference. Others of us may find these images less rich and less available, as we remember that we weren't there! All of us though can continue to learn from the richness of the conference, and the myriad of ideas, techniques, and perspectives that were shared.

In this issue Robin Spiro reviews a presentation of the Self-Soother or Self Stimulator Mode in Cluster-C Patients given by Truus Kersten and Guido Sijbers. Continuing the discussion of working with Cluster C Patient, Remco van der Wijingaart and Guido Sijbers provide an overview of their presentation on Work With Healthy Modes and Cluster C. Patients. Eammon Smith writes about the Mode Inventory, and Rob Brockman writes about his work with patients with Generalized Anxiety Disorder.

Vivian Francesco introduces a man who needs no introduction: ISST President Dave Edwards. Learn where he finds his Happy Child Mode!

With this issue we introduce a new feature. We are fortunate to have a number of Special Interest Groups, or Forums. These groups are exploring different issues in depth, asking fascinating questions and struggling together with the challenges inherent in their focus. When possible we will update you on the work these forums are doing. In this issue we focus on The Trauma Forum: Their Mission Statement and a review of topics/papers they have addressed so far.

Finally, we would like to hear from you! Is there a topic you would like to write about and share with the membership? An idea your working with, population you're struggling with, application of the model you're excited by? We'd love to hear from you!

Warmly,

Co- Editors, Lissa Parsonnet (USA) and Chris Hayes (Australia)

In this February Issue

Vienna Conference Review

Cluster- C : From Addiction to Connection. Working wth the Self Soother or Self Stimulator in the Cluster C Patients: The Hidden Addiction Mode

by Robin Spiro LCSW (USA)

Truus Kersten and Guido Sijbers focused their presentation on patients with Cluster C diagnoses: those who are avoidant, dependent and/or obsessive compulsive. These patients often avoid vulnerable emotions in general, anxiety in particular, through hidden addictions which serve as a Self-Soother or Self-Stimulator mode. Often they are seen as process addictions like excessive and out of control time spent on video or computer games, porn or shopping. These patients may also present with a strong Detached Protector, Compliant Surrenderer and Perfectionistic Overcontroller mode.

The presentation began with a youtube video defining addiction based on the work of Johann Hari. Both entertaining and thought-provoking, the video posited that addiction is a symptom of disconnection in society and that the cure is meeting our innate needs for bonding and connection.

Truus and Guido described how to explore compulsive behaviors which could be Self-Soothers, learning about their origin, frequency, triggers and function, in a nonjudgmental way. During treatment the patient becomes aware of the costs associated with avoiding emotions through these behaviors, and the Healthy Adult is strengthened to tolerate emotion, provide empathy to the Vulnerable Child, and take control of the Self-Soother.

Using the case example of "John," Guido and Truus developed a mode map and helped him see that his "hobby" of spending many hours on computer games was a Self-Soother mode. They skillfully demonstrated through chair work how the therapist first respectfully learned about the Self-

Soother's perspective and function, i.e., keeping the patient away from intolerable experiences of social awkwardness and rejection. The vignette showed how stubborn a Self-Soother can be in believing in the necessity for its function. The therapist first modeled a Healthy Adult, asserting to the Self-Soother that he wanted to have a chance to learn to feel comfortable in social situations, and then the patient felt empowered to confront the Self-Soother.

Truus and Guido asked the audience to break into small groups to experience approaching our own avoidant Self-Soother modes under the direction of a facilitating "therapist," and to develop a dialogue between our Healthy Adult and Self-Soother. This consolidation of learning provided an opportunity to practice the skills they had demonstrated and to experience the feelings of the Self Soother, Healthy Adult and Therapist.

Vienna Conference Review

Working on the Healthy Modes and Cluster C personality disorders (PD)

By Guido Sijbers Clinical Psychologist (Netherlands)

In this workshop Remco van der Wijngaart and Guido Sijbers presented how to work on the healthy modes in general, using a cluster C patient as example. John, a patient with an Obsessive compulsive personality disorder (OCPD) to illustrate how to work on the healthy adult (HA) mode.

The occurrence of Cluster C PD's is characterized by excessive anxiety, control or inhibition. They probably cohere with a combination of a genetic predisposition and environmental factors (for instance problematic parenting styles, emotional abuse in childhood and repeated negative experiences in social contacts).

Although the associated behavior with Cluster C PD is more predictable and clinicians experience less crisis driven situations, the treatment does go with specific challenges. Particularly the rigid nature of this type of Personality Disorder can make such treatments more frustrating endeavour for therapists than anticipated on at the at the start of treatment.

OCPD's are characterized by an inability to accomplish a healthy balance between play and spontaneity and achievement, coming from an upbringing witch an overemphasis on control and performance. These patient can be extremely rigid and so John was a nice example to show how to use a phased approach to help a patient to work on and strengthening the healthy modes.

We decided to show how a few steps of how to implement working specifically on healthy modes in the course of therapy

Make dysfunctional modes egodystonic

John comes into therapy with a strong identification with, what in schema therapy is called, his dysfunctional coping modes. Until he came in therapy the maladaptive coping seemed the wisest, safest and most sensible thing to do in moments of (anticipating on) stress.

The therapist, on the other hand, using the mode model, needs him to understand that there are more modes defining John. Moreover he wants John to understand that these coping modes are one of the

main sources of the problems he seeks help for. One of the first goals will be to make this egosyntonic coping mode more egodystonic.

“Until he came in therapy that maladaditive coping seemed the wisest, safest and most sensible thing to do”

Apart from investigating and understanding the short and long term consequences of this dysfunctional coping, a lot of experiential work has to be done to also experience that his coping need to change. And typically, even if Cluster C patients even then, there often is quite some resistance to change in real life. Often leaving therapist with feelings of inadequacy and frustration.

By pointing out when a particular mode is active and allocating each one a particular spot in the room, helps the patient not only to understand but also to experience the mode model. Consequently also learning which part is the health mode.

Remco van der Wijngaart added to this how he learns his trainees to underscore this process by the using more explicit hand waves.

Fill in the Health Adult mode

Making dysfunctional modes egodystonic does not automatically mean that healthy attitudes and thinking is being learned.As a next step we focussed on the importance of filling in the healthy adult mode, by introducing how to distinguish different aspects of this mode and learning them in several steps.

Judith Vanhommerig, a psycho-dramatherapist participating in a phase oriented group schema therapy model, developed in Maastricht, based on the Farrell and Shaw model, designed three steps to help patients work on the HA mode already early in therapy. One of the advantages is that every step can also be practiced separately.

3 steps for filling the healthy adult mode

1) **Recognition: I see that you …. I hear that you ….**
2) **Invalidate (parent mode): It’s not true that …., because…**
3) **Inspire with hope: I know that you can ….., because …., you are good at …**

In group therapy, patients can help each other practicing this, with each playing different roles or changing positions.

We showed how to introduce the several steps in individual therapy. In the start the therapist can model the HA, the patient being the recipient. Later roles can be reversed or more modes can participate. The therapist can then choose to participate in the chair technique or guide the patient in the playing different sides himself.

We showed a technique, used halfway through the therapy, were John is guided to play the vulnerable child mode on the one side and the three steps of the HA mode (using three separate chairs) on the other. John, having become familiar with the three steps, practices them all tree. An important focus here is to have the patient experience the familiar feeling of inadequacy on one side, opposite to experience the HA points of view on the other and the various effects.

John in the HA chair is saying (if needed the therapist completes with suggestions):

1. “I see that you are afraid. I hear that you believe there is no room for emotions and enjoying.”

2. "It is not true that you are lazy when doing pleasant things instead of something useful; it's impossible to always be in control; because play and spontaneity is a basic need and an important ingredient to strengthen relationships and to keep a good balance in life."

3. "I know that you can do this, because you have been changing here in therapy, you're not always in your controller mode and you more and more connect with your emotions; you are good in persevering, you also already changed things in your life (talk to your wife about emotions and her needs, talk about you need for connection with her)."

Strengthening the HA mode

In the last part of the cluster C therapy (behavior change) there is a stronger focus on strengthening the HA.Here we showed a videoclip were we could see how John, preparing for behavior change, is practicing imagery in the future in two steps:

1. being aware of what mode is being activated (self monitoring) when trying new behavior

2. learning to switch to the HA mode (consciously use HA mode resources).

Use of humor in a therapeutic way

Finally Remco van der Wijngaart talked about how he started to use humor in a therapeutic way to strengthen healthy modes (HA and happy child mode) and to practice new behavior with John.

Especially John needs to learn to appreciate play and spontaneity for finding a healthier life balance. Moreover does his wife need him to be more open for positive sharing.

Examples of using humor in therapy are:

-sharing funny youtube clips

-exchanging jokes

-brainstorming about what nice things he could plan with his wife

- having the patient try this outside therapy

We can imagine that for John it isn't easy to appreciate more play and spontaneity at once. The therapist needs to explain how the patient can benefit from this and to persevere.

Recent Schema Book/ Chapter releases

Vuijk, R., & Arntz, A. (2017). Schema therapy as treatment for adults with autism spectrum disorder and comorbid personality disorder: Protocol of a multiple-baseline case series study testing cognitive-behavioral and experiential interventions. *Contemporary Clinical Trials Communications*.

de Klerk, N., Abma, T. A., Bamelis, L. L., & Arntz, A. (2017). Schema therapy for personality disorders: a qualitative study of patients' and therapists' perspectives. *Behavioural and Cognitive Psychotherapy*, 1-15.

Stevens, B. A., & Roediger, E. (2017). Schema Therapy. Breaking Negative Relationship Patterns: A Schema Therapy Self–help and Support Book, 8-28.

Renner, F., Arntz, A., Peeters, F. P., Lobbestael, J., & Huibers, M. J. (2016). Schema therapy for chronic depression: results of a multiple single case series. *Journal of behavior therapy and experimental psychiatry*, *51*, 66-73.

Fassbinder, Eva, et al. "Feasibility of group schema therapy for outpatients with severe borderline personality disorder in Germany: A pilot study with three year follow-up." *Frontiers in Psychology* 7 (2016).

Bach, B., Lee, C., Mortensen, E. L., & Simonsen, E. (2016). How do DSM-5 personality traits align with schema therapy constructs?. *Journal of personality disorders*, *30*(4), 502-529.

ISST Special Interest Group Online Trauma Forum

Mission Statement

The ISST Special Interest Group (SIG) on Trauma is a group of Schema Therapy clinicians who are interested in sharing our experience of working with traumatized patients within the schema therapy framework. Our interests cover any clinical presentations where unresolved traumatic experiences play a role. This includes Acute Stress Disorder and Posttraumatic Stress Disorder, whether arising from a single adult traumatic event, or repeated traumas in childhood. We are particularly interested in complex trauma where early traumatic events set up patterns of schemas and coping that may present as personality disorders (especially borderline personality), eating disorders, treatment resistant depression and panic disorder and dissociative disorders including Dissociative Identity Disorder.

We are interested in broadening our understanding and seeing how case conceptualization with the schema therapy model can sharpen the focus of our therapy work. Our participants have experience and expertise in several current treatment models used for working with trauma (e.g., various CBT models such as Prolonged Exposure, Cognitive Reprocessing Therapy, EMDR, and approaches to working with severe dissociative states). One of our interests is in how specific approaches or techniques can be integrated within the broader framework of Schema Therapy case conceptualization. In this way, we may also contribute to research by developing and clarifying concepts within the schema therapy approach and identifying some needed research areas in the trauma field.

Join us! You don't have to be an expert in trauma to join the SIG and attend the online forum. You will be part of a warm, friendly, active group of ISST colleagues who have different levels of expertise in the trauma field. We are fortunate to have our new president, Professor Dave Edwards, as an active member as well as Dr. Arnoud Arntz as our consultant. Several other members are leaders in the field and have presented workshops at Schema Therapy conferences.

Our meetings started in June 2016 and take place once a month (i.e., usually the second Monday of each month) at 8 AM US Eastern Time. They one hour and we use the Go to Meeting online platform. You will be sent a link to log in to our meetings using your computer, iPads , smart phones, or a telephone line.

During our meetings we usually have one of us present a trauma related paper which is a trigger for questions and discussion.

Following the spirit of Schema Therapy, forum participants are encouraged to be polite, friendly and respectful with each other as we are sharing both what we know but also what we do not know and would like to learn. We need to take good care of our "Little Children" who may sometimes feel insecure, overwhelmed and lost when working with certain patients. Our group will offer a safe atmosphere in which you will improve your knowledge of trauma work and feel inspired and motivated to apply what you learn to your own patients.

TOPICS/PAPERS ADDRESSED BY THE TRAUMA FORUM IN PAST MEETINGS

1) Discussion of Dr. Arntz's excellent trauma paper: Imagery Rescripting for Posttraumatic Stress Disorder (in Working with Emotion in Cognitive-Behavioral Therapy, Edited by Thoma and McKay). As mentioned earlier, Dr. Arntz has accepted to be our consultant and has answered some group's questions about his paper.

2) Dr. Edwards' presentation of his thourough paper about Integrative Treatment forTrauma: "Responsive Integrative Treatment of Clients with PTSD and Trauma-Related Disorders: An Expanded Evidence-Based Model" Group discussion and a Q and A followed his thought inspiring presentation

3) Dr. Patricia Escudero Rotman interviewed Dr. Edwards about some topics raised in his trauma paper. This meeting included group discussion

4) Dr. Mary Giuffra shared with our group Peter Levine's Somatic Therapy model. Discussion and a Q and A regarding the model and its integration with Schema Therapy followed the presentation

Future Meetings of the Trauma Forum will include these topics among others:

1) How to integrate the Somatic Therapy model to Schema Therapy. Many group members believe we should include more "body based interventions"in our ST model

2) Treatment of Acute Stress Disorder

3) EMDR and its possible integrations with our Schema Therapy model

We are open to more suggestions about possible topics from our existing and future SIG members. Many group members are also available and interested in offering online and site therapy, online supervision, and trauma therapy training. They can be contacted through their emails (please see ISST website).

If you are interested in joining this SIG please contact the chairperson, Patricia Escudero Rotman at drpatriciaescuderorotman@gmail.com

We look forward to hearing from you!

Warmly,

Patricia

Dealing with Pathological Worry and Rumination: Proposing a new 'Over-Analyser' Coping Mode

Dr Robert Brockman Clinical Psychologist & Adele Stravopoulos Clinical Psychology Trainee, University of Technology, Sydney, Australia

The Importance of Addressing Rumination and Worry in Clinical Presentations: How Do We Formulate it in Schema Therapy?

Rumination is defined as the process of repeatedly focusing on one's present distress, as well as its causes, meaning and consequences (Papaeorgiou & Wells, 2004). In contrast, worry is defined as 'passive, repetitive thoughts about future negative events with an uncertain outcome' (Papagreorgiou & Wells, 2004).Both cognitive processes have considerable clinical significance, and are thought to be central to the development and maintenance of depression and anxiety disorders respectively (Watkins & Moulds, 2005). An increasing body of evidence suggests rumination and worry are transdiagnostic constructs, found to be elevated in chronic cases of psychological disorders across the board (Teasdale & Barnard, 1993), including personality disorders (Martino et al, 2015). Moreover, rumination and worry are associated with poor treatment outcomes, and are both a common residual symptoms after treatment remission (Jones, Seigle and Thase, 2008).

Traditionally, worry and rumination have been perceived as distinct cognitive constructs, differing in both thought content (worry involves themes of anticipated threat, rumination focuses on past loss or failure) and temporal orientation (worry is future and rumination past oriented; Papagreorgiou & Wells, 2004). Yet emerging evidence suggests these constructs share more similarities than differences. Both are repetitive, difficult to control, negative in content, predominantly verbal, relatively abstract, and strategies in response to initial intrusion (Watkins & Mould, 2005).More recently, Nolen-Hoeksema & Watkins (2011) have proposed a transdiagnostic model, in which rumination and worry are part of the same underlying process of Repetitive Negative Thinking (RNT), which does not vary once controlling for disorder-specific content. Multiple findings support this model, namely that worry and rumination have been found in individuals with either a mood or anxiety disorder, and did not differ depending on the disorder (McEvoy, Moulds &Mahony, 2013). These findings elucidate why treatment specifically targeting this construct has been found to reduce both disorders, indicating that this over-arching construct may add increased clinical utility (Nolen-Hoeksema & Watkins, 2011). Figure 1 below demonstrates that repetitive negative thinking can be placed on a time continuum with past oriented thinking (rumination) on one end, and future oriented thinking (worry) on the other.

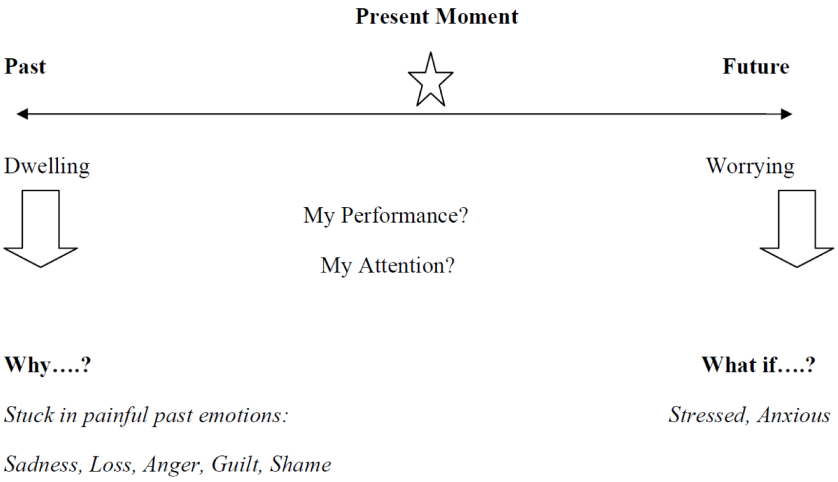


Figure 1.

Repetitive Negative Thinking Serves an Avoidance (Coping) Function

There is general consensus in the CBT literature that repetitive negative thinking (rumination and worry) serves an avoidance coping function. Experiential avoidance is defined as both an unwillingness to remain in contact with aversive private experiences, and action taken to alter events that elicit them (Hayes, 2004). Borkovec and colleagues' have put forth a model which proposes that worry is an experiential avoidance strategy which functions to reduce experiencing the full impact of fear imagery associated with anxiety(Borkovec, Alcaine, Behar & 2004). Worry is a predominantly linguistic strategy, and verbal articulation of feared material causes less sympathetic nervous activity than imagery (Shearer & Tucker, 1981). Worry is also characterised by abstract thinking, which produces less vivid and frequent images, and is thus less likely it is to evoke somatic responses than imagery (Borkovec&Ruscio, 2001). Thus, by switching attention from fear imagery to worrying (a verbal-linguistic activity), individuals with anxiety suppress autonomic arousal, negatively reinforcing this verbal-linguistic behaviour.Similarly, rumination is a linguistic strategy, characterised by abstract thought (Papaeorgiou& Wells, 2004). Significantly, experiential avoidance predicts unique variance in depression scores (over and above anxiety and rumination; Moulds et al., 2007). These results suggest worry and rumination each function as a form of experiential avoidance, through focusing individuals on the verbal content of distressing material, limiting its emotional impact (Moulds et al., 2007).

It could be argued that Cognitive Behavioural Therapy (CBT) techniques (such as cognitive restructuring) may be ineffective at times to treat rumination and worry, as it promotes verbal processing, and has the unintended effect of blocking the emotional processing needed to challenge dysfunctional beliefs (McEvoy et al., 2015). High residual rates of rumination and worry following CBT for depression and anxiety suggest that this may not be an effective approach (Watkins, Mullan, Wingrove, Rimes, Steiner, Bathurst, Eastman, Scott, 2011).In contrast, Borkovec (2004) advocates for the exploration of further emotive techniques designed to access and modify threat schemas on an emotional level, to effectively treat rumination and worry.

Researching A Schema Mode Model of Worry and Rumination

Borkevic's model of worry and rumination has overlap with Young's Schema Mode Model (2006) which similarly conceptualizes maladaptive coping as ultimately functioning as experiential avoidance. Further, there is an increasing body of evidence that Schema Therapy mode formulations are effective in the treatment of chronic and treatment-resistant presentations, which do not respond to standard cognitive-behavioural therapy (Hawke &Provencher, 2011).

"Rumination and worry may function as a maladaptive coping mode ('over-analysing') with an ultimate avoidant function in response to aversive emotional states

Our lab carried out two studies aiming to examine whether pathological worry and rumination could be conceptualised as an 'over-analysing'coping mode, consistent with Young's Schema Mode Model, which serves to distance individuals from distressing emotional states. Study one investigated the relationship between four schema modes (Healthy Adult, Contented, Angry and Vulnerable Child), pathological worry and experiential avoidance in 109 anxiety suffering adults who completed an online survey. Correlation and multiple regression analyses supported a schema mode model of pathological worry, revealing that experiential avoidance fully mediated the relationship between the angry child and vulnerable child modes, and levels of pathological worry

Study two extended these results by examining the relationship between the schema modes, experiential avoidance, rumination and repetitive negative thinking in 129 adults who completed an online survey. Similarly, correlational and mediation analyses revealed that the relationship between the schema modes, rumination and repetitive negative thinking was mediated by experiential avoidance. These findings are consistent with the CBT literature on repetitive negative thinking, and the notion that rumination and worry may function as a maladaptive coping mode ('over-analysing') with an ultimate avoidant function in response to aversive emotional states (angry child, vulnerable child, inner critic modes).

These findings support a hypothesised model of mood and anxiety disorders as displayed in Figure 2. This model suggests that when faced with triggering events (thoughts, emotions, images or urges) which threaten to evoke emotions of vulnerability, anger, or shame/guilt (inner critic state), an individual may engage in 'over-analysing', characterised by verbal-linguistic analysis (repetitive negative thinking about past or future events), which reduces awareness of aversive emotions and reduces physiological arousal. Through operant conditioning 'over-analysing' becomes negatively reinforced, causing its escalation over time. Furthermore, through inhibiting emotional processing of the triggering event, over-analysing impedes problem solving, which leaves personal concerns unresolved, triggering further repetitive negative thinking and causing an escalation in symptoms over time.

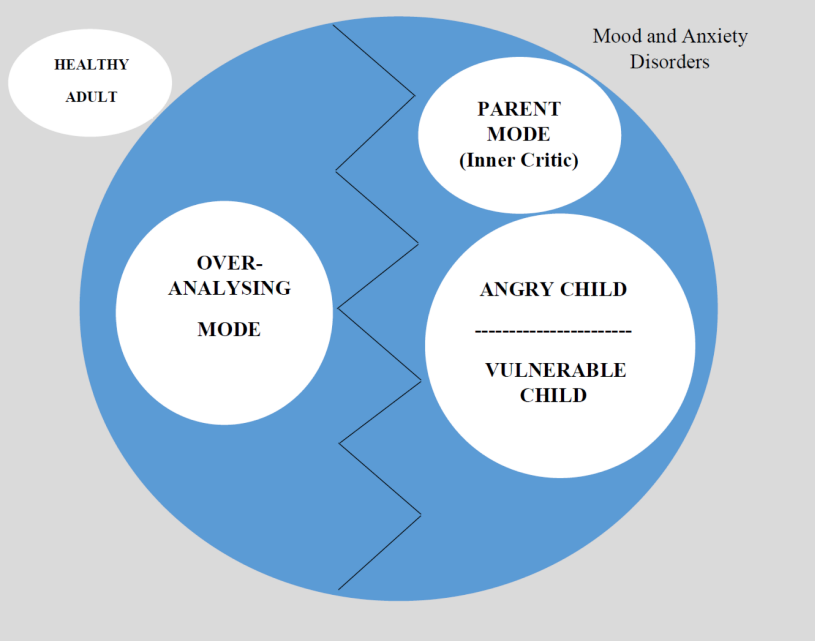


Figure 2. Proposed schema mode model of repetitive negative thinking, mood and anxiety disorders

An initial definition of the 'Over-Analyser' Coping mode

We propose that an 'over-analyser mode' can be defined as a state in which there is a focus on the verbal-linguistic processing of past and/or future events (in the form of rumination or worry), at the expense of attending to experiential and emotional features of present experience. As the over-analysing mode functions to block emotional processing of threat schemas, this may result in the maintenance of the underlying schemas and ongoing problems in need satisfaction.

Clinical Implications

The present findings need further research but suggest that rumination and worry can be conceptualised as a coping mode with an ultimate avoidant function, and thus repetitive negative thinking states (e.g. worry and rumination) can be clinically formulated in Schema Therapy as an 'Over-analyser' coping mode. As this hypothesised coping mode takes the form of 'over-doing something' (thinking), we suggest that it may be best thought of as an over-compensatory coping mode, albeit with an ultimate avoidant function. As such the goal of schema therapy for these patients in session would be to bypass abstract, verbal linguistic processing in session (over-analysing) though the regular means of increasing mode awareness, pros/cons, labelling, and attunement etc, so that the therapist can connect to the underlying feelings and schemas and provide healing via emotive interventions and limited reparenting. Conceptualisation of this mode also opens the door for exploration of so called '3rd Wave' techniques such as mindfulness as a way to help patients limit their over-analysing and spend more time in the present moment where they can be more attuned to needs and feelings.

The Problems with Modes and their Measurement

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(Based on a paper presented at the ISST Vienna Conference 2016)

The concept of modes is one of the central pillars of schema therapy and, for many, has become the primary focus of therapy. The different definitions of the concept encompass a range of theoretical positions from cognitive therapy to object relations. Young et al. (2003) defined modes as *'those schemas or schema operations-adaptive or maladaptive- that are currently active for the individual'* and as *'a facet of the self involving specific schemas or schema operations that have not been fully integrated with other facets'.* Flanagan (2014) defined modes as *'adaptive strategies for satisfying needs, having behavioural, affective and cognitive components'* and are conceived to be 'roles' rather than traits. Others have commented on their theoretical similarity to concepts such as 'ego states' and 'splitting' from other therapeutic models (Edwards & Arntz, 2012). What the different definitions have in common, however, is that modes are not unidimensional constructs but contain a number of theoretically related components. I believe that there is a misalignment between our theoretical understanding of modes and our knowledge derived from empirical studies, which thus raises the following concerns.

Although clinically specific early maladaptive schemas (EMSs) have been observed to be associated with certain modes (e.g. Emotional Deprivation, Abandonment and Vulnerability with the Vulnerable Child Mode) particular EMSs are not exclusively associated with individual schema modes (Young et al. 2003). Little attention has been given to the specific mechanism by which EMSs and modes are related.

Modes comprising EMSs, various coping responses and behavioural dispositions can be expected to change over the course of treatment by the deactivation of the EMSs and modification of the coping response. Again, the mechanism by which modes are expected to change has received very little theoretical or empirical attention.

Likewise, there are few theoretical studies that specifically address the issue of modes and psychopathology. Increased mode activation has been related to severity of psychopathology and specific modes have been associated with certain personality disorders. However, evidence for these assertions comes, in the main, from studies using the Schema Mode Inventory (SMI). Even when clinically determined, there appears to be little integration with theory.

"Can a unitary score on an inventory reflect the multiple components of the concept? Does the SMI measure what we theorise as modes??

From an original ten, the number of modes has now approached thirty, with the ever-increasing list of schema modes cited as an attempt to grapple with the complexity of clinical presentations. It is hardly surprising that a mode titled 'Self-Aggrandiser' might be required to describe a narcissistic presentation or that Conning and Manipulative mode and Predator mode might be required in forensic settings. Modes, instead of being perceived as 'unintegrated facets of the self', are being increasingly used as broad behavioural descriptors of presenting behaviour and symptoms. This point has been well made by Flanagan (2010), who also questions the utility of the ever-growing lists and observes that the original purpose of the concept was to simplify the schema model.

The reciprocal relationship between the theoretical understanding of modes and results from studies using the SMI can be problematic. There is a danger that theory will be modified on foot of the SMI in a similar manner to that of the Young Schema Questionnaire (YSQ), where, based on studies of the reliability and validity of the instrument, changes have been proposed regarding the basic model. In this case, Lockwood & Perris (2012) proposed a shift from the five- to a four-domain model, which was subsequently endorsed by Young (2014). More recently, based on their reliability and validity exploration of the SMI, Panzeri et al. (2016) made a theoretical jump by concluding that the theoretical structure of the model was strong and, therefore, that schema therapy itself as an approach in evolution is a promising treatment for personality disorders. While the over-interpretation of an instrument such as the SMI may be problematic, the very instrument itself is questionable from both a conceptual and technical perspective.

The proliferation of modes raises a basic question about the feasibility of measuring modes as the SMI assesses, at best, just fourteen. If the number continues to grow we will be left with an inventory of indeterminable length! More importantly, however, there are conceptual issues around the use of the SMI. Firstly, how can a measure be developed that will reflect the situational triggering of a specific mode and simultaneously assess the characteristic modes utilized by an individual, given that modes are said to contain EMSs which are conceived as traits? Pilot studies carried out on earlier instruments found that subjects had difficulty in separating, on the one instrument, currently active modes from general modes (Lobbestael, 2012.). Secondly, can an instrument measure both the intensity and presence of a mode given the theorized relationship between intensity of mode activation and the level of psychological distress? Indeed, Lobbestael (2012) cautions against the use of a non-clinical sample in studies

of modes because they are more likely to score low on the 'pathological modes'.

Despite its widespread use, there have been relatively few studies that have examined the factor structure of the SMI. Some studies have confirmed the fourteen-factor structure (Lobbestael et al. 2010; Reiss et al. 2011, 2016; Panzeri et al. 2016). However, other than making assumptions regarding the intercorrelations among the various modes, there have been no studies that have examined the different categories of modes as independent models.

Smith et al. (2016) tested the modes as unifactorial models to examine the convergent validity of the items. The modes and their individual items were brought together in their various categories, i.e. innate child, coping, parent and healthy, which tested their discriminant validity. The modes were then fitted into a full model, firstly, as correlated categorises and then as third-order factors. With some questionable modifications to the item content of the individual modes, the confirmatory factor analysis largely confirmed the structure of the modes in terms of their items. When included in their respective categories, there is some question of overlap, as the fit indices were not overly convincing, although using more lax criteria (CFI index >0.85) and incorporating the item modifications, the fit might be regarded as adequate. However, the overall fit of the model, being poor, suggests that the categories of modes may not be sufficiently discriminating because of significant overlap among the modes.

All the modes were moderately to strongly correlated with measures of general psychological distress and well-being. Intercorrelations among the different categories of modes is cited as evidence of their cohesion and, indeed, Smith et al. (2016) did find significant correlations among the modes within the various categories. However, all the maladaptive modes regardless of category were significantly correlated. That the correlations among the modes did not reach r= 1.0 cannot be regarded as evidence for their individual integrity, as suggested by Panzeri et al. (2016).

In summary, Smith et al. (2016) found some evidence for the fourteen-factor structure but only following significant modifications to the items initially and the further use of a questionably lax interpretation of some of the goodness-of-fit indices. The modes were also significantly correlated with each other regardless of category and, furthermore, all the so-called maladaptive modes were significantly related to degrees of psychological well-being.

The results raised some fundamental questions for the authors (Smith et al. 2015; Smith, 2016). For example, have we fully explored and explained the nature of the concept? Is the scale not just a further measure of distress or lack of well-being? Do we understand the unnecessary reductionist position that can be adopted when using such instruments? Can a unitary score on an inventory reflect the multiple components of the concept? Does the SMI measure what we theorise as modes?

The core concept of the interpersonal mode model focuses on the mode cycles between the coping modes of the partners.

If modes are indeed theorized to be the situational responses to triggered EMSs and only exist within the context of an external or internal relationship with another and if schema therapy is a relational therapy, then surely the patient's interpersonal narrative and the therapeutic relationship itself is the 'royal road' to unearthing the self–other dyads, the connecting affect, and the characteristic coping strategies or defences. To prematurely provide the patient with a personal understanding of constructs, which, may in part, be based on the interpretation of a questionable instrument is a violation of the 'not knowing' stance, which is an essential ingredient in the therapeutic encounter. Vulnerable patients are often acquiescent and eager to please the therapist and will often acknowledge interpretations as representing the true contents of their minds. While schema therapy does not solely rely on the YSQ or the SMI, nevertheless the provision of a simple instrument that will short-circuit more in-depth exploration can be attractive, particularly for the more novice therapist. Are they ever told that the SMI may not measure what they assume it measures?

Maybe it is time to get back to the basics again and look afresh at the whole structure of the modes and rather than attempting to describe them according to results of studies using the SMI, we should examine the theoretical structure in terms of the interpersonal relationship and decouple the concept from notions of psychopathology.

Another course of structural exploration may be to examine the relationship between concepts such as 'internal working models' and EMSs/modes, and, subsequently, assess what self–other representations and coping strategies are associated with specific modes. At a broader level, perhaps the relationship between these core constructs may be examined by reference to other related clinical approaches, such as the Core Conflictual Relationship Theme of Luborsky and Crits-Christoph (1990) or the interpersonal affect focus (IPAF) of Lemma, Target, and Fonagy (2011). Should modes and EMSs be operationalized in terms of a broad template such as these, then there can be as many mode operations as there are different minds and mental operations. Flanagan (2014) has, from a more cognitive therapy stance, proposed a matrix model for modes as one possible structure which deserves further attention.

While the above comments refer to modes and the SMI, similar observations can be made about the nature of EMSs and their measurement using the YSQ (Smith, 2015). To monitor progress through the course of therapy by using measures of symptom severity is acceptable but, when the instrument purports to measure concepts that are integral to the theory of the therapeutic endeavour itself, we should proceed with caution.

Interview with Dave Edwards- ISST President

by Vivian Francesco (USA)

I recently had the profound pleasure of interviewing Dave Edwards and was amazed to discover so many different facets of our new ISST president. Here are some excerpts from our interview:

What role do you play on the ISST board? What made you want to accept that role?

One of the jobs of the President of any board is to serve as an administrator, keeping the agenda on point and the group focused. Since I have served in this sort of position before, I felt confident in my ability to serve as president of the ISST. The President should have a strong belief in the model and preserve the integrity of schema therapy above all else. I value the model and have been very fortunate to have worked personally with Jeff Young and others who believe in the importance of clear case conceptualization, for example. I value my experience serving on various committees of the ISST throughout the years (Training, Supervision and Certification Committees). I would never have thought of applying for the presidency, but people approached me and asked me to serve. I remember being really quite surprised! I guess that's because, being from South Africa, I tend to feel somewhat on "the edge of things" or maybe it's because of my "social isolation schema"!

How did you first learn about schema therapy?

In 1984, I came from South Africa to Beck's Center for Cognitive Therapy in Philadelphia. I heard Jeffrey Young lecture about schema therapy, and I thought it was the greatest thing on the planet! I had already written about using imagery in psychotherapy, and I was already integrating guided imagery and chair work into my practice, so hearing Jeff Young speak about schema therapy at that time was very affirming and it worked well with where I was heading.

How did you get your training in schema therapy?

I already had a small practice which was quite integrative because I was trained in CBT, experiential techniques and Gestalt, and quite a lot of my colleagues were using a sort of relational approach to therapy. I went to many lectures and read everything about schema therapy. I guess I'm sort of self-taught, although I did attend many of Jeff's workshops. I was truly very guided by Jeff's writing. He gave me his training packet which I have found to be indispensable. I was grandfathered in, but I had to submit a session tape and a case conceptualization to Wendy. It was an eating disorder case, that I later presented at some workshops including one in Germany. Subsequently, it was published in a book in German on Schema Therapy for Eating disorders edited by Christina Archonti, Eckhard Roediger, our former President, and Martina de Zwaan.

How did you first get into schema therapy?

Meeting Jeff Young in 1984 was, of course, a turning point. I had already been working with integrating experiential techniques into CBT, but this was just what I needed to focus myself in the right direction. In 2007, I gave a presentation in Barcelona where I met Arnoud Arntz and became very excited about the Dutch research on Schema Therapy for Borderline Personality. Soon afterwards, I attended a workshop of Arnoud's in London and saw some of the Dutch training DVDs. Stimulated by this, I started a schema

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Interview with Dave Edwards- ISST President

therapy study group and watched and discussed the whole set with a group of colleagues At the time I was certified, I was was preparing to retire from my full time position as university professor at Rhodes University. I decided to "rebrand" myself as a schema therapist and trainer. I still work part time for Rhodes, but much of my time now is devoted to doing schema therapy with clients, and offering supervision and workshops.. Schema therapy is very complex and I'm still learning how to do it. In fact I learn something new nearly every day so I'm not ready to retire yet. I think, eat and breathe schema therapy!

What do you see in the future for the evolution of schema therapy and the ISST?

The main thing I would hope for is the continuation of really creative work being done by so many ISST members in developing the application of schema therapy to a broad spectrum of disorders. I see this clinical creativity being increasingly grounded in a growing body of published research, and this marriage is exciting for the future of schema therapy.

How do you enjoy spending your free time?

Well, I'm somewhat of a workaholic, and my wife, who is a neuropsychologist and researcher is too, though she's doing better at giving it up. So we're working on that! (He chuckles.) We both love hiking. We try to carve out vacation time every couple of months. We just took a lovely holiday at the beach. If we are traveling for work, we try to combine it with some leisure travel.

How do you get into your "happy child mode"?

If I think of when I'm best in my "happy child", it's when I'm with my grandchildren - I have seven and use a spreadsheet to keep track! Last year, we joined all my children and grandchildren in Bali for a vacation they had planned. I was a very happy child!

I also access my "happy child" when I am being creative. I have fun taking popular songs and doing schema therapy commentary to them to present at workshops. One of the songs I used at a couples workshop in Vienna was "It Ain't Me Babe" by Bob Dylan. In the commentary I suggest it might be better if he and the "babe" went for Schema Therapy for couples instead of resorting to avoidant coping!

Are there any other thoughts or ideas you would like to share with the ISST family?

I feel very honored to have been elected President of our wonderful Society. I am also aware that I am just one of a large number of committed people who value and work for the ISST. I am very grateful to be working with some of these fine people on the Executive Board and to know there are many others working on our committees and subcommittees or in other ways working to move Schema Therapy forward. I think the challenge for schema therapy is expanding the model to include a wider range of clinical problems while maintaining the integrity of the model. This is something that, as President, I will stand for and promote. Since schema therapy is so diverse technically, there is a danger of getting caught up in specific techniques. Schema therapy isn't defined so much by techniques as it is by how you use them within the framework of a schema therapy case conceptualization. As the integrity of the model is something people like Jeff, Wendy and Eckhard value as well, I feel very comfortable being President.I know I am following in the footsteps of, and am supported by, many of the major players in schema therapy who have helped to build and strengthen the ISST and helped it to become the rich, diverse and effective organization it is today..

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