

THE SCHEMA THERAPY BULLETIN

The Official Publication of the International Society of Schema Therapy



Schema Therapy is an evolving model due largely to our members' creativity, courage, thoughtfulness, insight, and commitment to helping clients. These traits are highly evident in the work of the authors contributing to this edition of the Schema Therapy Bulletin..

In this issue Lynda Parry provides a history of the use of dreams in psychotherapy, and then discusses her use of dreams to access the Vulnerable Child Mode in therapy. Her article thoughtfully explores key questions including the degree to which such work could accelerate symptom reduction while ignoring underlying causes, particularly in the case of complex trauma; by “manipulating” dreams are we “short circuiting” some of the work the brain needs to do to process information and function optimally; and by working with dreams could we underuse the therapeutic relationship in ways that may prevent growth and healing or are therapeutic dysfunctions inevitable and their repair an aid to healing? Parry provides an important overview of sleep and dream stages, outlines the history of dream work in CBT, and the importance of timing in working with clients' dreams.

Lisa Elizabeth Irvine provides a Schema Therapy perspective on Parental Alienation Syndrome, a problem particularly relevant to clinicians working with children of divorce. She conceptualizes the triangulation that can occur in these situations as the wounded parent compensating for feelings of defectiveness and shame, and to escape the Vulnerable Child Mode by engaging in overcompensating modes, which have the effect of enlisting the children to protect the wounded parent, thus alienating the other parent, now seen as a perpetrator, or Punitive Parent. This creates a paradigm of victim, perpetrator and rescuer, with the children co-opted to serve the needs of the alienating parent. Irvine elaborates on the challenges, both clinical and ethical in working with this dynamic.

Wendy Behary and Liz Lacey provide an overview of their presentation in Amsterdam discussing “Narcissism, Shame and Intimacy: Dealing with the unmet needs of the narcissist. Behary and Lacey describe the thrill seeking self-soothing detachment that many narcissists seek through sexual exploits. They make the distinction between sexualized efforts to evade feelings of

defectiveness and shame, and true intimacy, which could actually heal those feelings. Schema Therapy approaches to workings with this population are described, with an emphasis on knowing and coping well with one's own schemas.

Finally Sally Skewes provides in introduction and overview of "Secure Nest" a self-education "e-health" tool" developed to help people assess and understand their own schemas and modes, and recognize their triggers.

We continue call for contributions for upcoming issues of the Schema Therapy Bulletin. If you have an article or want to propose a contribution please make contact....

Lissa Parsonnet, (USA) & Chris Hayes (Australia)

Narcissism, Shame, and Intimacy: Dealing with the Sexually Self-Absorbed and Healing the Fractured Trust

Wendy Behary, LSW & Liz Lacy (USA)

Derrick walks into the office, a tall, attractive successful, charming man, who is angry at his wife. Yes, he tells you indignantly, he had 3 affairs and multiple anonymous sexual experiences through an online venue throughout his 15-year marriage, but he has been sexually sober three months. "How could she still be so angry? She should be proud of me!"

From celebrities to political figures to the everyday individual... We have been bombarded by the news media in the U.S. with the recent meteoric rise in attention to acts of sexual misconduct, the sexual predators, perpetrators, addicts, and general sexual preoccupation. It is no surprise that we, as therapists, find ourselves continuing to peer into the important underlying explanations and evaluate the potential for helping individuals and relationships affected by these behaviors and attitudes to heal.

Exploring the specific issues and critical content related to sexual activity can be, albeit incredibly important to conceptualization and treatment, an uncomfortable endeavor for many therapists. We need to be extraordinarily sturdy in our own skin when it comes to sexuality, personal feelings and biases about infidelity, and our deep understanding of the functions of sexualized modes and schemas. Add to that... the capacity to address the belligerence, self-righteous entitlement, denial, and arrogance of a narcissistic client with hypersexual modes.

"We need to be extraordinarily sturdy in our own skin when it comes to sexuality, personal feelings and biases about infidelity, and our deep understanding of the functions of sexualized modes and schemas"

Schema Research

Bach, B., & Bernstein, D. (2018). CURRENT OPINION Schema therapy conceptualization of personality functioning and traits in ICD-11 and DSM-5. *Curr Opin Psychiatry*, 32, 000-000.

Basile, B., Luppino, O. I., Mancini, F., & Tenore, K. (2018). A Theoretical Integration of Schema Therapy and Cognitive Therapy in OCD Treatment: Experiential Techniques and Cognitive-Based Interventions in Action (Part III). *Psychology*, 9(09), 2296

Fassbinder, E., Assmann, N., Schaich, A., Heinecke, K., Wagner, T., Sipos, V., & Schweiger, U. (2018). PRO* BPD: effectiveness of outpatient treatment programs for borderline personality disorder: a comparison of Schema therapy and dialectical behavior therapy: study protocol for a randomized trial. *BMC Psychiatry*, 18(1), 341

Fassbinder, E., & Arntz, A. (2018). Schema therapy with emotionally inhibited and fearful patients. *Journal of Contemporary Psychotherapy*, 1-8.

Simpson, S., Simionato, G., Smout, M., van Vreeswijk, M. F., Hayes, C., Sougleris, C., & Reid, C. (2018). Burnout amongst Clinical and Counselling Psychologists: The Role of Early Maladaptive Schemas and Coping Modes as Vulnerability Factors. *Clinical psychology & psychotherapy*.

Treating the narcissistic client involves helping them to get their early unmet needs met; including the need for unconditional love and acceptance, empathy, and tolerance for frustration and limits. This comes with the challenge of confronting bullying, critical, and approval-seeking modes.

In this group of patients we see the merging and sexualizing of the detachment and overcompensating modes...into a hypersexual, thrill seeking, self-soothing detachment mode that also functions to take them far from feelings of defectiveness and shame. As in most mode activation, this mode ends up reinforcing their early maladaptive schemas. One of the keys to successful treatment is helping the patient to experience the original unmet needs in order to appreciate how this self-destructive mode only perpetuates these painful old feelings, in spite of the acute stimulation and disconnect from distress.

This is no easy feat, since the behaviors often feed the narcissist's approval-seeking needs and self-aggrandizement, among others. A careful balance of empathic confrontation and limited reparenting are necessary for healing and adaptation to evolve. Most, if not all, of these patients have histories involving intense emotional deprivation, especially nascent sexual developmental needs, such as healthy sexual boundaries, healthy messages about sexuality, positive body image and a need for touch and affection. Some additionally have had enmeshment, resulting in blurred boundaries regarding the patient's ability to distinguish between healthy sexual contact and real intimacy.

Behaviors that collude in this cycle happen along a continuum of escape from real intimacy (least amount of intimacy to most): pornography to cyber sex chat to video chat to massage parlors and escorts to "love" affairs. Important to note here is that the love affair helps the narcissist remain in rescuer mode, seeking the thrill of the moment, without true intimacy that occurs in a real love relationship. It's important for the therapist to understand the function of the behaviors in order to fully grasp the core unmet needs of the patient.

Intimacy suffers and relationships become

fractured as a result. As with other narcissists, these patients tend to seek treatment when they are facing the threat of a significant loss, such as a spouse or partner. The refurbishing of trust is a challenging but achievable goal when leverage is high enough (meaningful consequences for refusal of therapy) and partners are willing to engage in the treatment process individually and together, ultimately.

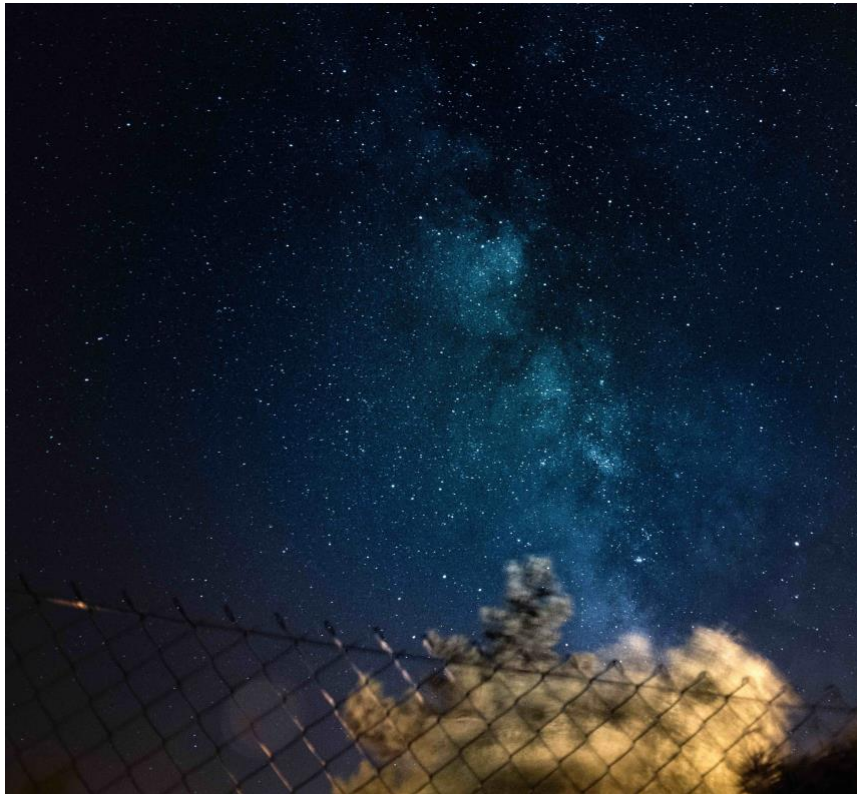
The heart and soul of schema therapy offers an approach capable of weakening these maladaptive modes and self-defeating, demanding modes. Adaptive responses replace maladaptive ones as schemas heal. The schema therapist, through the use of effective strategies grounded in emotional engagement and the therapy relationship, is poised to correct early emotional experiences typically linked with high demands for extraordinary performance, confusing messages of over-indulgence, inadequacy, and insecure attachments, devalued emotional experiences, and poor limit setting.

The schema therapist confronts the defiant detachment mode by using empathic confrontation to leverage the high price of remaining disconnected from important emotional experiences, helping the patient to see how the vulnerable child has been sequestered by this mode, despite its worthy function when the patient was young and powerless. For example, *“Of course this work seems weird to you Derrick. You were taught that emotions and neediness were signs of weakness, that you were a failure of sorts when you showed any fear. You were given the distinct message that you should not need affection, emotional closeness, or comfort. So, you did the best you could to not feel those feelings and to focus on your performance. But you are, after all, a human, a child, and of course you needed that just as every child needs to feel securely loved and connected without conditions attached. Little Derrick still longs for that. And when you feel that longing, unbeknownst to you because it happens behind the scenes, you reach for some pseudo form of intimacy, a quick fix, or a rush—a stimulating distraction. And, little Derrick is further exiled from getting his needs met.”*

Herein lies the launching pad for imagery and emotion focused work, for limited re-parenting and narrative re-scripting within the archives of memory. We start with the therapy relationship as a resource for confronting the moment-to-moment (challenging) encounters with schema modes in the treatment room, ones that act as close-enough replicas of the narcissist’s relationships outside. We bring these modes into the light making them explicit. Diving deep into an understanding of memory activation and the automaticity of emerging rigid patterns for coping with unresolved pain sets the stage for further tracking and (empathically) making sense out of harmful hypersexual impulses that have consequentially served to defeat the quest for sustainable satisfaction in the patient’s intimate life.

This therapeutic stance seems also to be critical to the restoration of trust in relationships—narcissists need to work from the inside out when it comes to empathic attunement to their offended partner.

Meaning, they must first become empathically connected to their own vulnerability to understand how their modes (including the hypersexual modes) became constructed, before they can begin to resonate with the skin-felt experience of a betrayed partner. This is a daunting task for even the cleverest of therapists when not conducted in this order. It is very difficult, if not



impossible, for narcissists to appreciate the impact of their betrayal on a partner when they are busily defending the “bad guy” or trying desperately, through watery self-serving apologies, to get “off the hook”. It appears that deconstructing modes and schemas and developing a highly attuned appreciation for their misconduct as part of a maladaptive mask, begins the process for reconnecting with their vulnerability and being better able to walk in the shoes of a wounded partner.

Schema Therapy and Dreams - Accessing The Vulnerable Child Mode

Lynda Parry,

Clinical Psychologist,

Schema Therapy Centre of New South Wales, Australia

www.schematherapycentrensw.com

In his book *The Interpretation of Dreams* (1899) Freud heralded dreams as the royal road to the unconscious. Now almost 130 years later we know that the highway of dreams is in fact a two-way street. Lived experience influences dreams and dreams, even when they are not remembered, influence our waking experience. Research into dreams and sleep reveal exciting results and have led to new ways to work with patients’ dreams. This knowledge changes how we conduct therapy using dreams. Patients usually report enjoying dream work and consistently rate working alliance, insight and session quality significantly higher when dreams are included in therapy sessions (Wonnell & Hill, 2000).

Psychotherapy has always been interested in the meaning of dreams and curious as to what purpose they serve. Since Freud’s notion of dreams as defensive carriers of repressed yearnings many others have entered the arena contributing to our current understanding of dreams as a sophisticated process that includes cognitive, affective and neuropsychological activity from the elemental to the most complex forms. Differing views of the purposes and meanings of dreams

reflect how the self is conceptualised in various models of psychotherapy. From a Schema Therapy perspective, dream material is viewed as a valuable source of communication and a golden opportunity to enter into a person's inner world of modes, schemas and their dynamics.

Dreams can reveal the maladaptive coping modes, the child modes and their schemas, the relationship templates from childhood even before the patient is aware of them (Simard, Valerie & Laverdière, Olivier & Bedard, Marie-Michele & Brassard, Claudia & Merlo-Galeazzi, Hector. (2018). Dreams can be utilised to demonstrate these components of the person's functioning in a way that is wholly personal to the individual. Significantly spending time in a session exploring a patient's dream can often give access to the vulnerable child mode before the person is ready to bring that mode consciously into the therapy room. What has been incommunicable can be expressed in dreams. The therapist can glean important information to begin to connect to the VCM and to store away for future use. Some dreams can be referred to numerous times over the course of therapy. In addition, dreams can inform patient and therapist of dysjunctions in the therapy and of the shifts towards health occurring in therapy.

So rather than defensive carriers or just random impulses generated from the pons (Ellis & Harper, 1975) there has been a paradigm shift that now understands that: -

1) dreaming is a creative process. This act of creation in the dreaming process is critical for the integration of corrective experiences in therapeutic treatment and their consolidation into the Healthy Adult Mode.

2) there is a reciprocal influence between the dreaming process and the therapeutic process. CBT does not generally include a focus on dreams and most therapists report no inclusion of using dream content in their training (Crook, 2004). There have however been recent developments that utilise CBT techniques to work with patients' dreams (Krakow, 2004, Barrett, 2001). Barrett sums up the current thinking of CBT in her statement "dreamwork used to be about interpretation. Now it's about influencing dreams, asking dreams about particular issues and changing nightmares". She uses two techniques in her work dream incubation and lucid dreaming both of which are aimed at training sufferers of PTSD and Complex Trauma who experience nightmares to gain mastery and actively change their dream imagery. Krakow (2010) of the Post Traumatic Stress Sleep Disorder Clinic in New Mexico conducts imagery rehearsal with sufferers of PTSD. These techniques are similar to ST's guided imagery and rescripting techniques and can be easily incorporated into a schema therapy practice. Both of these approaches manipulate virtual reality with the anticipated effect of changing a person's lived experience. They can lead to the reduction of nightmares and recurring dreams.

"From a Schema Therapy perspective, dream material is viewed as a valuable source of communication and a golden opportunity to enter into a persons inner world of modes, schemas and their dynamics"

They do however raise the questions

- 1) Could such an approach lead to fast reduction of symptoms while failing to address the underlying cause?
- 2) In the case of Complex trauma do damaging childhood experiences need to be understood and corrected for lasting recovery?
- 3) Do dreams play a significant role in brain function and if so what are we doing if we seek to manipulate that process?
- 4) Is the healing effect of a corrective therapeutic relationship, humour, play and creativity ignored?



For a more thorough discussion of how dreams have been viewed from the CBT perspective I refer the reader to an earlier paper *Is Dream Analysis Obsolete* (Parry, 2010). Schema Therapy includes CBT interventions but has expanded to include experiential interventions and developed a

theoretical model that includes childhood development and the concept of schema modes. Guided by limited reparenting our therapeutic approach differs significantly from CBT. Schema Therapy answers questions 1,2 & 4 with its emphasis on modes and schemas and techniques to modify maladaptive coping modes into healthy adult and child modes. ST has been demonstrated to not only reduce symptoms but to address unmet childhood needs enabling enduring change to occur.

Studies on sleep, dreaming and memory have provided us with information to address this question 3. To summarise, dreams and sleep are controlled by different brain mechanisms (Solms, 2000). There are 2 major types of sleep: Sleep non-REM(NREM) and REM sleep. There are also two phases of sleep: slow wave (the deepest) sleep, 80% of which occurs in the first 4 hours, and late sleep in which the amount of REM sleep is doubled. This domination of early sleep by SWS sleep and late sleep by REM has been found to have important functional consequences particularly in the area of procedural memory. In addition, damage to the dopaminergic pathway results in loss of dreaming. Dopamine is a neuromodulator involved in procedural memory.

Dream content varies as a function of sleep and time of night. There is now evidence that dreaming occurs during NREM sleep. In NREM dreams the memory systems required to generate episodic retrieval are functional and are concerned with processing and storing recent experience. REM dreams are uncoupled from time and space. The memory system believed to be operating in

REM dreams is implicit memory. Implicit memory links previous experience with current events and is the sort of memory ST acknowledges as operating when schemas are activated.

Dreams and sleep affect memory consolidation in a complex way. REM sleep may be preferentially important for the consolidation of procedural memories and some types of emotional information whereas NREM, especially SWS, appears to be critical for explicit, episodic memory consolidation. Patients deprived of REM sleep show lapses in memory (Sohms, 2000). REM dreams memory consolidation occurs in a different neural system concerned with processing new knowledge with lifetime knowledge (Zhang, 2009).

The conclusion from these studies is that the processes of memory storage are subjective and changeable. In REM dreams superimposed images are created that connect new experience with previous experience it matches. Significantly while these images reveal the common aspect of the two they create a gestalt greater than the sum of its parts. The outcome of a dream is therefore a reorganisation of memory where past and present are interwoven in a way that changes both. New reality is consolidated (Stickgold & Walker, 2008). In light of this I am suggesting when patients experience their unmet childhood needs being met (limited reparenting) in ST sessions this experience will be consolidated in their REM sleep. What is significant here is that rather than manipulate the dream, it is the patient's waking experience of repair in the session that changes the dream. A dream can consolidate healthy growth through the creative act of visual imagery.

Because dream content is uncensored the VCM and other child modes often appear directly, unlike in session where the vulnerable child mode is usually hidden behind a MAC. They can take various forms for example babies are often present. The depiction of the baby reveals the schemas within the VCM, for example foetus like (emotionally deprived), deformed (defective) or damaged (abuse). Sometimes the baby literally grows in a series of dreams over the course of therapy. It is a great moment when the happy child appears.

Another form the VCM often takes is a house or a building, the state of which reveals the underlying schemas, or a vehicle of some kind say with no driver (abandonment) or the person is sitting in the back seat (enmeshment/undeveloped self). Since the imagination is so rich there are infinite ways the child modes can be expressed - the angry child mode may be represented as a monster like the salivating wolf in the dream described later in this paper.

This uncensored material is very useful as it gives the therapist ready access to the child modes. Often the patient has not yet connected to these modes and will present them as - "I had this really weird dream that doesn't make any sense". To the Schema therapist they make perfect sense. The task is to help the patient begin to recognise, own and nurture these parts of themselves

Schema Therapy Webinar Series

A monthly 90 minute webinar series presented by the ISST and free to members. See the recorded webinars at the ISST website.

Schema Therapy for Complex PTSD, by Chris Hayes

Dealing with Angry Patients: Tips & Tricks for Therapists
by Remco van der Wijngaart

Schema Therapy for Grief by Dr. Gemma Gladstone

More to come in 2019

For example, one patient had repeated dreams in which her house had open spaces where the doors and windows should be (vulnerability to harm). After a session where I lent her my Healthy Adult Mode to protect the VCM against an abusive partner she reported having a dream that night of a house with a front door. Over the next few months she would spasmodically share dreams in which the house had windows and finally a security door. This process was validating not only for the patient but for me also.

In utilising dreams in therapy, the practitioner needs to be aware when to manipulate a dream/nightmare and when to let the therapeutic work change the dreams. This is the focus of the workshops I present. As previously mentioned dreams can also inform the therapist if they missed the mark in session. To illustrate these points and the use of dreams in schema therapy I will describe the dream of one of my patients. This example has been de-identified, the person is no longer in therapy and has given consent for the material to be used.

“Patients experience their unmet childhood needs being met (limited reparenting) in ST sessions this experience will be consolidated in their REM sleep”

This dream occurred in the middle phase of therapy. The patient was referred for treatment of an anxiety disorder and somatic complaints. She suffered from disabling migraines the frequency of which did not respond to pharmacological treatment. She reported feeling lost, not knowing who she was and often experiencing overwhelming feelings of terror, pain and resentment. She spent a great deal of each day mostly alone engaged in soothing activities or visiting the chiropractor. She experienced an intolerance to many foods and had eliminated them from her diet so that her dietary range was very limited. In ST terms her detached protector and detached self-soother were firmly in place.

For the first few weeks she could barely tolerate therapy sessions, was easily disorganized by slight changes in the physical or interpersonal environment in the room. If I didn't mirror her exactly, for example, by changing a word she used to one of my own when expressing understanding, she would disconnect and begin to talk of her physical pain. Since she was unable to make any connection between her physical pain and the wounding she experienced when feeling misunderstood we decided to focus our work together on the physical level. I lent my Healthy Adult Mode to balance out the influence of her perfectionistic over controller and

gradually she was able to recognise her physical needs and stay within her limits instead of pushing herself beyond them. As she developed a sense of mastery over her eating, sleeping and exercise her migraines began to decrease. Interestingly she also reported the feelings of terror had modulated into fear and she felt less resentful.

At this time, she went on a holiday with her mother. She found the experience very frustrating as she spent most of the time in the compliant surrender, self-sacrificing modes considering her mother's needs and neglecting her own. Her migraines returned. On her return she stated she was ready to work on her relationship with her mother. She described her mother as a difficult, selfish woman with strong sense of entitlement and envious feelings towards her. At first when I empathized with her deprived self (VCM) she became contemptuous but when I empathically confronted her contempt she realized she was afraid of her vulnerability and mistrusted her needs. She became distressed and disorganized but instead of fleeing into physical pain was able to remain present and receive reassurance that she was safe in my room and her needs were important to me (limited reparenting). Next session she shared the following dream

There is a tree growing out of a cliff. The tree is alive and tall. It has a sturdy trunk and branches but no leaves. I am sitting in the juncture of the tree where a branch joins the trunk. In my arms is a baby. I am sitting koala style in this nook and curled protectively over the baby. On the top of the cliff is a salivating wolf.

I would love to say that we then went on to do a mode analysis, management plan and began to work with the mother and baby in this dream as the emerging healthy adult and vulnerable child modes. This did not occur however because in my excitement about the presence of the mother and baby in this dream my positive response was too intense for the patient to tolerate and she withdrew into her detached protector for the rest of the session. That night I had a shame filled dream and realized the next morning that my enthusiastic response had been experienced by the patient as me becoming the salivating wolf.

When we met next I expressed this to the patient saying I think my delight over the mother and baby was too much for her. I apologized and said I had been very moved by her dream because of what it possibly said about her emerging sense of self. She said she liked the warmth in



my eyes but got scared by my positive feelings because she felt this dream was one of the first things she had experienced for a long time that was truly her own. She said her mother had always taken everything good from her and shared a memory that typified this of going to ballet

lessons as a child and her mother having to have ballet lessons too. So now we could work

together on the real source of her pain and do rescripting and limited reparenting using these memories.

The patient continued to refer to this dream over many sessions and I held it in my mind for many more. She was fascinated with the salivating wolf and so I followed her lead and showed interest in this mode. We discovered that the frightening wolf image, which I had only associated with her appropriating mother (rejecting, demanding, guilt inducing critic), encapsulated not only the critic but the maladaptive (predatory) and child modes (vulnerable and angry) also. Unbidden the patient read a text book about wolves. She then informed me that healthy wolves are social creatures that belong in packs and it is only the damaged ones that become isolated, live alone and become mad. The multiple meanings in this dream informed her therapy - her past experience of being overwhelmed, controlled, appropriated and depleted was connected to her new experience of being held by me (she said I was the tree). She felt safe to leave her emerging healthy adult and happy child modes in my keeping while we attended to the salivating wolf. As her sense of autonomy grew stronger the patient moved from fear of the wolf to experiencing the rage within the wolf (angry child mode). Eventually she was able to empathize with the isolated depleted vulnerable mode inside the wolf that was desperate and ravenous with unfulfilled need. She began to own this vulnerable part of herself and nurture it using her own developing healthy adult mode. She began to show an interest in others, become playful and entered into an intimate relationship. As she stated at the end of her therapy “the lone wolf has gradually become a member of the pack” This article is intended to offer the schema therapist another medium for accessing modes and rescripting memories. Stories, music and images stir our imagination, stretch our experience and change our outlook. While we may not initially have all of the facts to back it up we get the deep message, the underlying meaning, through inductive thinking (Genter et al, 2001). If we omit exploring dreams as a source of information about our clients, we lose a method that is imaginative, quizzical, generally enjoyable and potentially deeply informative.

Lynda Parry is a Clinical Psychologist and an accredited advanced individual schema therapist, supervisor and trainer. She presents workshops called Schema Therapy and Dreams: Accessing The Vulnerable Child Mode.

See www.schematherapycentrensw.com for details.



Seeing Parental Alienation Syndrome Through the Lens of Schema Therapy: Proposals for Treatment

Lisa Elizabeth Irvine,

Clinical Psychologist, Adelaide, Australia

Psychologists working in the field of family law and high-conflict divorce are often exposed to the family-based attachment pathology known as Parental Alienation Syndrome (PAS). PAS is a subversive form of child abuse, in which the attachment bond between a child and an emotionally-available parent is deliberately undermined, and a perverse loyalty is formed with the Alienating parent after separation or

divorce. Family Systems Therapists call this a Cross-Generational Coalition¹ whereby the child is triangulated into the parental relationship in order to reject and vilify the Alienated parent. Earlier researchers have referred to the systematic alienation of one parent as the 'Medea Complex'², Malicious Mother Syndrome³ and Gatekeeper syndrome⁴. Others have claimed that PAS is analogous to the Factitious Disorder, Munchausen Syndrome⁵. Childress has since asserted that the underlying psychopathology of the Alienating parent is a Narcissistic Personality Disorder. If fact, he argues that that a strong diagnostic indicator of PAS is the manifestation of pseudo-

¹ Minuchin, S. (1974). *Families and Family Therapy*. Boston; Harvard University Press.

² Gordon, R. M. (1998). The Medea Complex and the parental alienation syndrome: When mothers damage their daughter's ability to love a man. In Fenchel (Ed.) *The mother-daughter relationship echoes through time*, (pp 207-225), New Jersey, Aaronson, Inc.

³ Turkat, A. (1997) Management of visitation interference. *The Judges' Journal*, 17-47.

⁴ Allen, S. M., & Hawkins, A. J. (1999). Maternal gatekeeping: Mother's beliefs and behaviour that inhibit greater father involvement in family work. *Journal of Marriage and Family*, 61, 199-212.

⁵ Rand, D. (1997). The spectrum of parental alienation syndrome: Part 1. *American Journal of Forensic Psychology*, (15)3, 1-50.

narcissistic symptoms in the child which have been modeled by the Alienating parent⁶. He argues that symptoms of grandiose entitlement to judge the Alienated parent from a ‘superior’ position, potent Splitting dynamics as well as a pronounced lack of empathy are amongst the various narcissistic ‘footprints’ found in children of PAS. Empirical research is supportive of these assertions. Research with parents undergoing family-court litigation suspected of PAS was conducted using the MMPI-2. PAS subjects showed extremely elevated scores on the K scale and extremely lowered scores on the F scale. Such patterns suggested the extreme use of primitive psychological defences typically used by people with the externalizing personality disorders (histrionic, borderline, narcissistic, and paranoid)⁷. In addition, research which relied on the systemic review of 270 divorce case files showed that parents who made false accusations of abuse during family court proceedings were much more likely to have been diagnosed with a Cluster B personality disorder by a treating professional⁸.

Parental alienation dynamics are often enacted after the Alienating Parent experiences the ego-injury consistent with divorce or separation, triggering schemas of Abandonment, Defectiveness, Mistrust/Abuse, Vulnerability to Harm and Punitiveness. At this time, an equivalency begins to emerge between the Alienating Parent’s Punitive Parent introject (embedded in the Alienating Parent’s traumatic attachment networks) and the ex-spouse through ego defences of projection and displacement. With the fusion of the Punitive Parent Mode (PPM) and ex-spouse, old feelings of defectiveness and shame are activated in the Vulnerable Child Mode (VCM) triggering the risk of narcissistic collapse. However, to bury the pain associated with the VCM and regulate schema activation, the Alienating parent deploys a set of over-compensatory coping modes which project feelings of inadequacy from the VCM onto the Alienated parent. These coping modes achieve this key endpoint by co-opting the child into rejecting the Alienated Parent by convincing the child that they have been the victim of long-standing abuse. In this way, normal sadness and loss are converted into paranoia and rage, leading to a “de-activation of the attachment bond”⁹.

Childress
postulates that the
Alienating Parent
recruits the child through
a subtle process of
emotional mis-



⁶ Childress, C. (2017). The Attach

⁷ Seigel, J. & Langford, J. MMPI-2
(16)4, 5-14.

⁸ Wakefield, H., & Underwager, R.
Sciences and the Law, (9), 451–468.

⁹ Bowlby, J. (1980). Attachment and loss: Vol. 3. Loss: Sadness and depression. NY: Basic Books.

attunement which activates the child's fight or flight response in relation to the Alienated parent¹⁰. Through this process, the child begins to experience a conditioned fear response and adopts the paranoid, false perception that the Alienated parent is a perpetrator and that they themselves have been abused and victimized (See Shared Psychosis, Folie A Deux¹¹). With the roles of 'Perpetrator' and 'Victim' in place, the Alienating parent then flips from the VCM into an all-powerful 'Rescuer' mode intent on segregating the Alienated parent and creating an enmeshed and hyper-protective relationship with the 'inauthentic child'. As such, the coping modes engineer a powerful role shift by pushing the VCM outside of the realms of conscious awareness and elevating the Alienating parent to a position of power during the trauma re-enactment. This tripartite model of Victim, Rescuer and Perpetrator is not new. Karpman first described this model in the 1968 and described how Narcissistic clients and their significant others often end up playing a role in what he refers to as the perverse 'Drama Triangle'¹². Bowen also described the idea of Emotional Triangles in families and purported that triangulation of a child can occur when a dyad (spousal relationship) is placed under stress¹³. These role distributions and boundary violations are clearly manifest in PAS families.

Alienating parents will often present to therapy in order recruit a third party professional into the 'campaign of denigration'¹⁴. Very soon into therapy the Rescuer mode will begin its indictment of the Alienated parent. Conceptualizing this in terms of schema modes, the Rescuer could be construed as a blended Self-Aggrandizer/Conning-Manipulator which will quickly begin to create an image of the Alienated Parent as defective, inadequate and dangerous whilst simultaneously projecting a self-image of virtuosity and hyper-protectiveness. However, as the Self-Aggrandizer is blended with a Conning-Manipulator it can often look and feel different to what we typically see in the Self-Aggrandizer mode of NPD clients. This is because self-promotion and devaluation will be coupled with assertions of victimization and vulnerability to harm. Careful examination nonetheless reveals a need to punish and isolate the ex-spouse as well as a powerful Splitting dynamics, whereby the Alienated parent is viewed as 'All Bad' (the PPM).

Reinforcing the Splitting dynamic, one will also find a potent Paranoid Over-Controller mode which works in tight coalition with the Rescuer. Throughout the course of therapy, the Paranoid Over-Controller will remain hypervigilant to all 'parenting errors' and will provide frivolous rationalizations in which neutral parenting practices are presented as major

¹⁰ Childress, C. (2014). Treatment of attachment-based 'parental alienation' of children. *Master Lecture Series*.

¹¹ Dantendorfer, K. et al. (1997). Induced hallucinatory psychosis (Folie A Deux Hallucinations): Pathogenesis and nosological position. *Psychopathology*, (30)6, 309-315.

¹² Karpman, S (1968). Fairytales and script analysis. *Transactional Analysis Bulletin*, 26(7), 39-43.

¹³ Bowen, Murray (1966). The Use of Family Theory in Clinical Practice. *Comprehensive Psychiatry*, 7(5), 345-374.

¹⁴ Gardner, R. (2002). Parental alienation syndrome versus parental alienation: Which diagnosis should evaluators use in child custody disputes? *The American Journal of Family Therapy*, 30, 93-115.

transgressions. This catalogue of transgressions is then presented to the therapist as further ‘evidence’ of abuse and aims to depict a chronic pattern of pathology in the Alienated parent.

These coping modes present a serious conundrum for the treating therapist. Therapists who idealize or validate the endeavors of the ‘hyper-protective’ Rescuer mode or who accept the ‘evidence’ of the Paranoid Over-Controller might inadvertently become a source of narcissistic supply whilst reinforcing the emotional abuse of the child. Given the vigour of these coping modes, therapists with Self-Sacrifice, Subjugation or Defectiveness schemas may experience strong transference reactions and may feel compelled to respond from their Compliant-Surrender mode. However, due to the serious ethical dilemma this would present³, it is imperative that the therapist stays in contact with their Healthy Adult mode in order to ensure they remain objective and refrain from any collusion with the false narrative. However, it is also commonplace that therapists who attempt to critically examine or question the validity of the child abuse concerns will be scolded or devalued by the coping modes and may even encounter a more virile Bully-Attack mode. Subsequently, it is likely that the Alienating parent will move onto the next clinician until they find someone to accept their distorted narrative of events.

Given the brittleness of the Alienating parent’s narcissistic personality and the self-protective functions of the coping modes, an effective therapeutic approach has yet to be consolidated. Yet Schema Therapy offers promising techniques. Ideally, it would be best to avoid challenging, questioning or scrutinizing the veracity of the ‘good parent / bad parent’ paradigm as challenging the Splitting defence will invariably result in a therapeutic impasse. Instead, Schema Therapy (ST) offers alternative approaches which will avoid direct reality-testing and therefore prevent the client from leaving their window of tolerance. Further, in order to overcome resistance, ST also offers us invaluable ways of interacting with Narcissistic clients to engender compliance with experiential work. Techniques such as empathic confrontation, transformational chairwork and ‘feeding the narcissistic’ can help to elicit willingness to explore the role of the past on present issues. The next step would be to re-create recent trigger situations within the context of the separation or divorce whilst using sensory experiencing and body focusing techniques to elicit emotional and physiological cues connected to the VCM. Techniques such as the Affect Bridge can then open the doorway to pertinent attachment imagery and the Alienating parent’s internal working model of the self, others and the world. Through imagery, the client can then be transported back to the trigger situation in order to explore how their attachment adversities and associated schemas hijacked their perceptions and experiences of the ex-spouse during separation. Generating such insight through moving between the past and present and exploring how the internal working model has been superimposed onto contemporary relationships is a pivotal step towards sculpting the meta-cognitive Health Adult mode.

In order to ‘hold’ the client during this emotionally provocative work, the therapist is best to adopt a posture of curiosity, acceptance and interest versus ‘expertise’. Such a posture will help to co-regulate the clients’ arousal states whilst they transcend into understanding and insight versus schema activation. Furthermore, by bypassing the coping modes and activating the attachment network through imagery, the necessary re-parenting work may begin in order to denounce the PPM and meet the core emotional needs of the VCM in order to enhance emotional tolerance and prevent mode flipping. Patently, we cannot collude with the coping modes or the

false narrative, but we must offer re-parenting messages of acceptance, empathy, safety and care for the VCM in order to provide corrective emotional experiences and prevent the Alienating parent from perceiving the therapist as yet another antagonist.

Further to the above imagery work, transformational chairwork can also help the therapist and client gain insight into the functions of the coping modes. In particular, interviewing the Rescuer and Paranoid-Overcontroller Modes on separate chairs can help the client identify when they as a child adopted the need to self-promote, restrict empathy, attack perceived antagonists or become hypervigilant to danger in the context of childhood trauma. Executing this ST technique will also enable the Alienating parent to see that such coping decisions existed long before the divorce and were instead selected in childhood as part of a survival response. In addition, the therapist can offer a three chair technique (3 x 2 chair technique) which can ‘chair out’ the perverse drama triangle as it existed historically and as it exists now. The PPM, Vulnerable Child and protector child modes can be offered chairs in a part of the room designated to the past. The Ex-spouse, real child and current coping modes can be offered chairs in a part of the room designated to the present. As part of this work, it will be useful to ask what the PPM chair said to / about the VCM chair at the time of the proposed separation and to help the VCM attribute their sense of threat, danger and vulnerability to the PPM versus the Alienated parent. The therapist can offer sentiments such as, “It would seem like this parent side is scaring Little X and telling her that she is defective and in danger. Could it be that your over-controller side has heard this parent side, but has thought it was your ex? Could it be that because you see Little X in your own child, your coping modes feel the need to protect her as they protected you?” Connecting the threat response to schema activation during separation versus episodes ‘child abuse’ and the ‘dangerousness’ of the ex-spouse will be pivotal for successful re-attribution and can help the client begin to fight the internal antagonist responsible for their pain.

Schema Therapy therefore offers a promising model that might not only address the underlying pathogenesis of Parental Alienation syndrome but enables the therapist to avoid any ethical or moral dilemmas posed by accepting and colluding with the coping modes which would maintain the abuse of the child. Further, by adopting an ST approach, the therapist will not only aim to heal the Alienating parent’s attachment traumas but in doing so, may help to salvage and even restore the child’s attachment security to both parents.

An individual’s insights into Secure Nest’s self-education program

*Sally Skewes, Secure Nest & Elly Gannon,
University of Adelaide*

Secure Nest (securenest.org) is an innovative e-health tool, which has been specifically developed for schema therapy. The platform offers a range of tools for therapists to support their clients, including programs which provide step by step guidance for therapists to facilitate blended short-term group schema therapy and individual schema therapy. Blended programs include a combination of face to face and e-health sessions. Secure Nest recently developed a self-education

program where individuals can learn about schema therapy. In this article we present an individual's insights into Secure Nest's self-education program.

The self-education program describes the schema mode approach in an understandable way for anyone who is interested in learning about themes in thinking and the related emotions and behaviours. The program aims to encourage individuals to change negative life patterns in such a way that they can respond to painful feelings and give more space to positive feelings in their life. The program can be used independently or as assistance to schema therapy with a therapist.

The self-education program guides individuals through a set of sixteen modules over three weeks. A range of exercises including imagery exercises and mindfulness recordings will help individuals to understand themselves, their feelings, schemas and core emotional needs.

Secure Nest recently sought feedback from individuals who completed the self-education program and we will walk you through the initial stages of the program (exercises from week one). One individual generously allowed us to share their experience.

An initial assessment at the beginning of the program provides an overview of an individual's schemas, related core emotional needs and coping style. The assessment results are displayed in an accessible overview in the My Modes (and Identify My Modes) feature.

Individual's experience: "The self-education program on Secure Nest was comprehensive and introduced me to what modes and schemas were. Part of the Self-Education program included filling out a questionnaire that indicates the main schemas in your life. My "top schemas" included the "Unrelenting Standards/Hypercriticalness" schema. This schema refers to having very high standards, perfectionist traits and as a result, being overly self-critical. For this schema, guidance in developing appropriate values and ideals, finding balance in achievement and personal needs are described, as core emotional needs."

In My Modes individuals can read about the schemas, modes and core emotional needs that are significant in their life. Individuals may find that they can already identify relationships between their schemas and modes and specific events in their daily life. Individuals can view the modes that are relevant in their life on the Identify My Modes page. This page has prompts for individuals to fill out mode diaries which provide a guide for them to organise their experiences when schemas or modes are triggered.

Individual's experience: "The next exercise involved creating a mode diary, which required me to log an example of how a particular schema was activated. This part of the task was initially difficult, as I felt that my schema did not relate back to an early childhood memory. I had always believed that my unrelenting standards were a result of the competitiveness in my studies. However, 3 days later (still puzzled by where my schema may have originated from) I realised that as a child I had always looked up to my brother, who to me, is one of the most intelligent people in my life. Because I admired my brother, I felt the need to ensure that I worked in a similar way to him. I was academic during my schooling years, and even as a young child I would get anxious if I did not succeed. These were standards that I had created myself, and even sympathy or reassurance from my parents would not appease me. The introduction to this task has made me reflect and recognize that this schema dates back much further than my tertiary education."

The next exercise involves illustrating one's schemas and modes which can be a helpful way to gain insight into how they function. Schemas and modes can be triggered by being asked to draw in this exercise. Individuals are asked to reflect on the exercise of illustrating their schemas and modes.

Individual's experience: "I found it interesting to illustrate my schema – it was a step forward in coming to terms with the fact that I admired my brother and aspired to succeed like him, and that as a result I have created very rigid and unrelenting standards for myself. My illustration represented me standing next to a drawing with a happy face (in green). Stemming from that positive drawing, I drew "thinking clouds" which pictured me standing next to a larger and improved drawing, with a speech bubble saying "if only it was bigger and better" (in red). I contrasted me being happy with my success in green, to me downgrading my success (in red). The illustrations do not include or make reference to any other people in my life, as this exercise has highlighted that my family has only ever offered me support and encouragement when I have been self-critical.

The illustration brought up the fact that doing schema therapy work is a very long process, as I know there is more I need to explore regarding my other schemas. The illustration also brought up doubts in myself as to whether I will be able to accept my accomplishments as they are. This has been a constant battle this year in in my studies, as I have been challenging myself to lower my own standards. Something, which I believe, I am making progress in!"

During the exercise when asked, what did you think? What did you feel like doing?

Individual's experience: "I honestly (and ironically) thought about my drawing skills after this task. I felt like I should discard of the illustration so that I could not be reminded of how I have perfectionistic traits, and so that others in my household would not come across the (poorly drawn) illustration! Another indicator that perhaps I have much work to do on this particular schema."

Overall reflection of the initial stages of the program:

Individual's experience: "I felt that this task has left me reflecting on the "top schemas" from the questionnaire I filled out. There is a lot of work I would need to do to wholly understand schemas, and to develop skills in linking schemas to different periods of my life."

Summary

The individual's reflection indicates that the self-education program may help individuals to begin to understand the origin of their negative life patterns and the related thoughts, emotions and behaviours.

The goal of this program is to provide access to some of the educational parts of schema therapy, including learning about one's schemas and modes and becoming aware of triggers in their life.

The self-education program is not designed to replace the change work of schema therapy with a therapist, but it may be helpful for some individuals (perhaps those with a stronger Healthy Adult or for those with difficulties that are not rooted in early attachment) if they are given a way to understand their long-term emotionally based patterns, and tools to apply in their own life to work out solutions with the help of friends or a therapist. This could initiate the change process, and they could then start schema therapy with a therapist to bring them through the change process.

Individuals can complete the self-education program (as homework) to promote connection and engagement between sessions or while on the waiting list, so they gain an understanding before beginning therapy.

Due to the integration of e-health tools being a new area of clinical practice and research in schema therapy, the possibilities for meeting individual's needs (or knowing who may benefit) are largely unknown and we should turn to our clients for their input.

Upcoming ISST events

Edinburgh May 1,2, 3 2019 - Schema Therapy "Enlight" Biannual Symposium (formerly Summer School)

Copenhagen 2020- Schema Therapy "Inspire" Conference (Date to be Confirmed)

References

Schema Therapy and Dreams - Accessing The Vulnerable Child Mode

Barrett, D. (2007). An evolutionary theory of dreams and problem solving in Barrett, D. & McNamara, P. (Eds) *The New Science of Dreaming*. Praeger/Greenwood. New York.

Crook, R. (2004). A Comparison of Cognitive, Psychodynamic and Eclectic Therapists Attitudes and Practices in Working with Dreams in Rosner, R., Lyddon, W. & Freeman, A. (Eds) *Psychotherapy in Cognitive Therapy and Dreams*. Springer, New York.

Ellis, A. & Harper, R.A. (1975). *A New Guide to Rational Living*, Prentice Hall, New Jersey, USA.

Freud, S. (1899) *The Interpretation Of Dreams*. J. Strachey (Ed), F. Deuticke, Leipzig & Vienna.

Krakov, B. (2004). Imagery rehearsal therapy for chronic posttraumatic nightmares: a mind's eye view in Rosner, R., Lyddon, W. & Freeman, A. (Eds) *Psychotherapy in Cognitive Therapy and Dreams*. Springer: New York.

Parry, L. (2000) *Dreams: Remembering, reviewing and reconstructing the self*. Paper presented at the Australian College of Psychotherapy Conference.

Parry, L. (2011) *Is Dream Analysis Obsolete?* Paper presented at "World Dreaming", the 6th World Congress for Psychotherapy, Sydney, Australia.

Simard, Valerie & Laverdière, Olivier & Bedard, Marie-Michele & Brassard, Claudia & Merlo-Galeazzi, Hector. (2018). Early maladaptive schemas in most recent dreams: Core fears never sleep. *Current Psychology*. 10.1007/s12144-018-9917-4.

Solms, M. (2000). Dreaming and REM sleep are controlled by different brain mechanisms. *Behavioural and Brain Sciences*, 23, 843-850.

Stickhold, R. & Walker, M. (2004). To sleep, perchance to gain creative insight? *Trends in Cognitive Science*, 8: 191-192.

Wonell, T. & Hill, C. (2001). Effects of including the action stage in dream interpretation. *Journal of Counselling Psychology*, 47, (3), 372-379.

Zhang, Q. (2009). A computational account of dreaming: learning and memory consolidation in *Cognitive Systems Research*, Vol 10, issue 2, June, 91-10