THE SCHEMA THERAPY BULLETIN

The Official Publication of the International Society of Schema Therapy

This Issue: Schema Therapy in Healthcare Settings

This second issue of the Schema Therapy Bulletin focuses on the use of Schema Therapy with medically ill patients. Unlike in more traditional applications of the model, the primary focus of medically ill patients is on disease management or cure, and the relief of physical symptoms rather than on psychiatric symptoms, relationship issues or other psychosocial concerns.

Depression, anxiety, personality disorders, psychosocial stressors, and schema eruption, have the potential to impede or derail the adjustment to a medical diagnosis and treatment, and undermine optimal medical care. The clinicians writing in this issue have found schema therapy to be well suited to address psychosocial issues that arise from the diagnosis and treatment of medical illness.

This issue will also feature the first of our ongoing "Meet the ISST Board" column. Thanks to Vivian Francesco for spearheading this column and helping us all get to know the Board Members whose tireless work keeps the ISST vibrant, focused and growing.

Our next issue will focus on Schema Therapy with Couples.

Editors,

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

Using the Schema Therapy Model to Help Patients Cope with a Cancer Diagnosis

Lissa Parsonnet PhD., LCSW , USA

In this October Issue

While nothing prepares a person for a diagnosis of cancer, one's entire life experience prepares a person to cope with cancer or other serious illness. A cancer diagnosis can ignite feelings of fear, anxiety, confusion, anger, sadness and overwhelm. It also threatens a person's identity as "healthy", and catapults them into the new and unwanted identity of "cancer patient". Webster's on-line dictionary cites the origins of the word "patient" as the Latin word patiens, or the Greek word pema, meaning "to suffer" or "suffering". How people adjust to this new identity of "sufferer", will impact the medical care they seek and receive, the treatment decisions they make, and their emotional experience throughout the illness process. It will also impact their family and friends, as well their relationships with family, friends, colleagues and their health care team.

The role of a cancer patient is extremely demanding physically, cognitively and emotionally/socially, and the "suffering" can occur in all these realms. Physical demands include coping with the impact of both the disease and of its treatments, as well as any self-care required. Cognitively it demands the rapid acquisition, processing and integration of information and language necessary to make informed decisions and comply with treatment protocols. Emotionally/socially one must be able manage anxiety and fear, trust in their treatment team, rely on their support system for help, accept assistance from others, clearly express their symptoms, needs and questions, take responsibility for getting needs met, ask for help when needed, cope with their new limitations, maintain realistic expectations of themselves and others, adjust to decreased contact with people in their "normal" lives (family, friends, colleagues, classmates, etc),

integrate new body image and adjust to changing treatment plans, schedules and medical personnel. Each of these challenges presents an opportunity for schema activation. When schemas are active it becomes more difficult to meet these challenges, especially under the pressure to make decisions, adjustments and accommodations quickly.

Early maladaptive schemas are an outcome of unmet childhood needs. Whatever adaptation an adult has made to his/her schemas can be undermined by the crisis of a cancer diagnosis, or the ensuing crises of making treatment decisions, initiating and undergoing treatment, completing treatment, and either adjusting to life after cancer treatment, or adjusting to a re-occurrence and the possibility of dying from the disease. The patient labeled as "crazy", "difficult", "in denial" or "demanding" may simply be a patient whose schemas are activated, and who is responding in a dysfunctional way. Understanding this can redirect treatment in ways that enable the patient to cope with the crisis of cancer in an adaptive and effective manner, as illustrated by the following patients:

A 42 year college educated, married woman with a complicated medical history was diagnosed with breast cancer. As she had with past illnesses, she complied stoically with the many demands of her treatment, no matter how unpleasant or painful. She was unable though to endure the fear, sadness, anger, frustration and disappointment that often accompanies the cancer illness process, and instead abused prescription medication, creating a group of additional, debilitating medical conditions, as way to subdue these (normal) feelings. This woman had no prior history of substance abuse.

The role of a cancer patient is extremely demanding physically, cognitively and emotionally/ socially

She was raised in a family in which the matriarch and patriarch (her grandparents, now deceased) never complained, about anything, not even when they were seriously ill. This stoicism was highly valued in the family, and it was understood that nothing upset her grandparents; this lack of emotional response to pain, struggle and suffering was a defining feature to be admired and emulated. This woman's substance abuse was understood as a strategy to avoid feeling shame that she had (unacceptable) feelings of sadness, fear, anger, etc., at her situation. Her substance abuse began to abate when she was able to discuss how inadequate she felt for not coping as her grandparents had, and about the demand she felt from the expectations of their legacy. She was able to recall in imagery the unconditional love and acceptance she experienced in her grandparents home, and then imagine her grandmother comforting her, telling her that it was ok to feel sad, scared and even angry that she was suffering, and that she loved her and was proud of her.

A 52-year-old married corporate executive with two college-aged children, diagnosed with early stage breast cancer suffered from extreme and unremitting anxiety that seemed even to her, disproportionate to her diagnosis. She responded to this anxiety by placing countless calls to her physicians and their staffs, seeking reassurance about every sensation she experienced, comment a well-intended friend or relative made, and news item about cancer. Her worries eclipsed everything else, dominating conversation with her husband to the point that he felt unable to engage productively in conversation with her, and preventing her from being able to work. Her medical team, though very supportive at first, was finding it difficult to meet her needs for reassurance and had become less responsive to her calls, increasing her fear. Though she tried to protect her children from her obsessive worrying, her ability to control herself was waning and her behavior was beginning to make her feel badly about herself as a mother. Exploration of her history, and examination of her schemas revealed that her father had died suddenly when she was 15 years old. She has vivid memories of him falling down, and of hiding in her room in fear, looking out the window as the

ambulance took him away. When the call came that he had died, her mother sent her to the hospital to identify his body, and then to inform her aunts and uncles of his death. Needless to say this teenager felt overwhelmed by, and unprepared for these tasks.. Her mother, who was described as "fragile", was immobilized by the loss of her husband, and unable to parent her overwhelmed daughter, who therefore felt alone with her distress, and confused by the sudden changes in her life. She remembers feeling scared and alone, unable to talk with anyone about what she'd endured, and the feelings of helplessness, overwhelm and inadequacy she experienced. She developed a vulnerability to harm or illness schema, as well as a negativity/pessimism and unrelenting standards schemas that are triggered only by health and medical related situations.

Because these schemas are only activated by health/medical events, she had not developed a means to effectively cope with them; nor had her family or friends who found her uncharacteristic behaviors puzzling and frustrating, as nothing they said or did seemed to help assuage her distress. She experienced some relief when we identified these schemas and their origins, and she was able in imagery to re-parent her 15 year old self. In subsequent exacerbations she was able to engage her Healthy Adult mode to reassure her overwhelmed, over-burdened and unprepared 15 year old self (Vulnerable child) that she (now) has the skills, maturity and resources to cope with whatever occurs. While attempts at reassurance by family and friends made her feel misunderstood and more alone, re-parenting and reassuring the vulnerable, over-burdened child reduced her anxiety, enabling her to respond to the demands of her cancer diagnosis and it's treatment in constructive, adaptive ways. The schema therapy

model is a useful tool in both understanding and addressing patient's adjustment to cancer.

Schema Therapy in Medical Settings

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Early Life Experiences and Health in Adulthood

Schema theory posits that life experiences promote the development of adaptive and maladaptive schemas through conscious and non-conscious cognitive, affective, and somatic experiences and inform the perception of ourselves, the world, and our future. When our developmental needs are not met, the theory implies that we turn to conscious and non-conscious behaviors (whether adaptive or maladaptive) to promote survival in an attempt to meet our cognitive, affective, and somatic need for autonomy, relatedness, and competency.

While the *direct* influence of maladaptive schemas on health conditions has not been examined, there is evidence that correlates adverse early life experiences to maladaptive behaviors and to health conditions in adulthood that go above and beyond the influence of gender, age, race/ethnicity, income, and educational level. Maladaptive behaviors include smoking, substance use, risky sexual behaviors, suicide attempts, poor diet, and health conditions that include chronic pain, diabetes, myocardial infarction, coronary heart disease, stroke, asthma, difficulty with maintaining weight loss after bariatric surgery, and spontaneous preterm birth. Moreover, adverse childhood experiences have been associated with multi-morbidity among patients with health conditions.

Schema Therapy Fills a Gap in Medical Settings

Integrating mental health professionals into medical settings acknowledges the interplay between mental health and physical health conditions and promotes access to mental health care by reducing stigma associated with mental health diagnoses. For example, a recent review of 40 studies found that nearly 45% of individuals who

ISST News

Schema Therapy TV-

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

Vienna 2016- Call for papers

The ISST welcomes contributions for the upcoming schema therapy conference. For more information visit www.scheamasociety.org

completed suicide had contact with a primary care provider within a one-month period of time before the individual completed suicide.

Currently, the majority of medical-behavioral interventions are guided by traditional cognitive-behavioral models that do not directly target and acknowledge the integration of cognitive, affective, and somatic experiences and their impact on health behaviors. While integrated medical-behavioral models are proving to be associated with positive outcomes for population health, in both mental and physical health conditions, much of the reported outcomes are clouded by selection bias and are focused on patients who are already engaged in treatment. In addition, the effectiveness of traditional cognitive-behavioral treatments in integrated medical-behavioral models are most effective for patients with mild-to-moderate chronicity and complexity, suggesting that treatments may not be identifying and targeting key mechanisms to promote change.

In my practice, schema therapy is filling a gap by expanding the current models in integrated behavioral-medical care from a strictly cognitive-behavioral model, to one that is cognitive-affective-somatic and helps me understand and facilitate behavioral changes. Further, there is also evidence to suggest that schema theory-developed conceptualizations may be more acceptable to patients compared to a diagnosis-based conceptualization and reduce stigma related to mental health.

Case Example # 1 Diabetes Management.

Jane, a 33 year old woman, whose type 2 diabetes was not well managed, was referred to me by her diabetes care coordinator. Jane participated in collaborative care focused on providing her with motivational interviewing, goal setting, and behavioral activation in order to promote her adherence to insulin. However, Jane was not adhering to her

insulin, despite her father having passed away from complications related to diabetes. Scores on Jane's depression screeners suggested that she had moderate depressive symptoms that were not improving. After a period of 6 months of lack of improvement, the collaborative care manager referred Jane to me for a consultation.

Integrating mental health professionals into medical settings acknowledges the interplay between mental health and physical health conditions

In our initial appointment, Jane reported that she *cognitively* understood that she had to monitor her blood glucose levels and take her insulin; however, she still has a difficult time adhering to the regimen. I obtained a brief life history from Jane. During the consult, Jane informed me of her father's passing, how she was the youngest of 8 children, and how she was bullied throughout childhood due to weight. In addition, Jane reported observing her parents surrendering to many preventable adverse life circumstances due to lack of education; she reported that her parents often verbalized that it was God's punishment. Using the original schema model, the schemas related to the domain of disconnection/relatedness came to mind and included emotional deprivation, instability, defectiveness, punitiveness, and social isolation/exclusion.

Linking schemas with presenting health issue.

In having these schemas available to discuss, Jane spontaneously provided examples of life experiences she also was able to bridge many of her experiences to her current difficulties. During the initial 50 minute period, Jane verbalized that she held the belief that she was being punished for something horrible she must have done at some point in her life - she was able to link this to the belief that mistakes warrant punishment - the punitiveness schema- and tied this to her observing this from her parents when she was

growing up. I engaged Jane in cognitive activities asking her to recall explicit memories that reinforced this belief. Jane stated, "When something went wrong, my parents would often say that God has a plan, and that you can't change God's plan, even when he is punishing us." From this cognitive awareness, Jane reported an underlying belief that "good" and "bad" things happen in an ebb and flow manner. Using limited re-parenting, I provided warmth and understanding, while also providing reassurance and challenging the cognitive belief that punishment is always warranted. "If God wants to punish you, why is it that he would put you in my care to help you with your diabetes?" We also focused on how the failure schema "talked" to the punitiveness schema. By the end of the session, Jane and I had collaboratively developed a case conceptualization and identified targets for our treatment that had not previously been addressed which served as barriers to adhering to her insulin. Subsequently, I spoke to the care manager and encouraged that a focus on small gains be amplified and to be aware of language associated with punishment or shaming. Since that time, Jane substantially increased her blood glucose monitoring and has steadily increased her adherence to insulin.

Schema Therapy and Physician Health and Development

In the United States, physicians, compared to non-physicians, have a two times higher odds of completing suicide. While no one single factor can likely explain this, I have noted significant levels of unrelenting standards and self-sacrifice. In addition, among physicians there is recent research that suggests that maladaptive schemas are associated with professional boundary violations against patients and suggests that health providers' schemas impact their decision making when working with patients. This suggests a role for integrating and addressing maladaptive schemas through targeted treatment and wellness programs.

In my role as a psychologist in a medical setting in primary (continuity care clinic), secondary (hospital service), and tertiary care (consultations to individuals with functional neurological/gastrointestinal disorders, somatic symptom disorders, etc) I have found that I have been able to engage patients whom otherwise would not engage in the existing integrated medical-behavioral models of care. These outcomes are not a coincidence, and while the researcher part of me attempts to keep my equipoise, the clinician part of me are excited about the future and seeing the research catch up to the practice of schema therapy in medical settings.

Meet the ISST Board- Eckhard Roediger

with Vivian Francesco

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

From the very beginning in Coimbra, Portugal in 2008, I have been a board member and was involved in its onset. When Wendy decided that she didn´t want to run for another board term she asked me if I could imagine becoming her successor. It took me a little while to consider this offer but finally she convinced me that I should not underestimate my talents. I hope she was right….

2.How did you first learn about Schema Therapy?

I first heard about Schema Therapy from a friend of mine who attended a workshop of Jeff Young in London in the spring of 2002. This friend said to me "Eckhard, what you are doing is very close to Schema Therapy." (I was already working with "parts of the self") After getting deeper into the issue I have to admit that Schema Therapy has much more to offer and learning from Jeff has taken me far beyond my horizon!

3. **What were you doing (professionally) before you heard about Schema Therapy? (position/ job/population/practice style or therapeutic model)**

I am trained equally in Psychodynamic and Cognitive-Behavior Therapy and I have always tried to integrate both perspectives. I met Klaus Grawe in 1996 and his integrative conceptual framework of psychotherapy gave me a compass for my attempts at searching for an integrative approach. He was a famous researcher in German speaking countries but although his major textbook has been translated into English almost nobody took notice of him. Jeff´s model to a great extend overlaps with his theory and I regard Schema Therapy as the practical application of Grawe´s theoretical framework. So this is the basis of my conceptual contributions to the ST model.

4. **How did you get your training in Schema Therapy**

Henry Berbalk invited Jeff for some workshops and supervision meetings and most of the training directors that lead the German ST-training centers participated in these trainings. In addition to that, Henry supervised our inpatient treatment unit in Berlin from 2004 onward where we worked hard to get deeper into the details of the model and its practical application.

5. **In your clinical work how do you use Schema Therapy? -How did you first get into Schema Therapy? What challenges do you see Schema Therapy facing?**

In my daily work with patients I almost solely apply ST. From the beginning I felt quite familiar with its essence and it felt like "coming home" or like a fish in the sea. I can say I am living Schema Therapy every day!

6. **How has schema therapy changed your practice? (with some specifics-the way you assess patients? the way you view patients and their issues? the relationships you form with patients? Treatment outcomes? The clients you choose to work with? etc.)**

The framework for my case conceptualizations became clearer and the experiential techniques brought a new "drag" into my work leading to a deeper emotional experience and a "felt shift" within the sessions for both the patients and me. In the clinic in Berlin we developed a computer based diagnostic program including all relevant questionnaires available for the public now. It makes the case conceptualization much easier. I feel ST actually works with all Axis-II-disorders.

Besides that, working with the ST model enriched my personal life very much more than all the self-therapy I have gone through; especially in dealing with my wife!!

7 What do you see in the future for the evolution of Schema Therapy and the ISST?

I see a chance to refine the model and the use of the techniques in detail. In the couples book recently published together with Chiara Simeone-DiFrancesco and Bruce Stevens I tried to work out the theoretical underpinnings of the model a bit more but I still see the chance to connect our case conceptualization and techniques more with the relational frame theory and contribute together with DBT and ACT to the development of contextual science based (so called 3rd wave) therapies. This is a very promising development going beyond conventional CBT. ST could become an essential part of this strong movement.

8 **How do you enjoy spending your time when you're not doing Schema Therapy?**

I am still involved in raising our 3 kids. If I am not writing books on ST, I am spending time with my wife, meeting friends, gardening and singing in a choir a really nice social experiment!

9. **How do you get into your "happy child mode"?**

In the activities outlined above, mostly with my wife for more than 30 years now, I enjoy nature very much, meeting friends and taking part in the cultural events of a moderately big city like Frankfurt. Life is beautiful!!

10. **Are there any other thoughts or ideas you would like to share with the ISST Family?**

Most of all I hope that we manage to apply the principles of ST on ourselves when it comes to solving conflicts among ourselves. In addition to that I think we need a good balance between keeping the core of the model straight while remaining open to including new ideas and techniques. The board is working hard to improve the structures and services for our members step by step and to invite more members to participate

I am trapped in a body I can't trust": Working with Patients who have Chronic Illness

Elizabeth Lacy, LCSW, USA

Lisa walks in to my office, tense, underweight and tearful. She tells me that she has had Chronic Lyme for about 6 years… she can barely swallow most days because of the almost constant burning in her mouth and throat. She has been to so many doctors she can't even count them and she just read an article in my waiting room that talked about the mind-body connection of illness. She starts blaming herself harshly "I don't think I'm doing enough. I know it isn't all in my head but I'm afraid it is. I've been sick since I was a kid, but this is ridiculous"…Monica, a 20 year old who is obese, has terrible panic attacks in college and has had severe rheumatoid arthritis since age 3. As Monica tells me about her anxiety, I can barely hear her through her flat affect. She has no idea what she thinks about anything, only that she can't tolerate the feeling of her anxiety. She describes how she gets a "wooshy feeling in my head like there is a Plexiglas window between me and everyone else" and this scares her to the point of not being able to drive alone, go to a store or see a friend. She said she has felt this out of body experience since she was young and in pain but never this severely. Her mother hands me a four inch thick stack of CBT skills and tools that she has been trying to get Monica to use. Mom says it's been the same with her RA since she was a child: "she just won't do anything about it. I give her lists but she never follows through!"

Treating people who have chronic illnesses is challenging to say the least. Back when I was treating people with more traditional CBT, patients who were extremely sensitive to physical sensations and the threat, whether real or imagined, of serious illness would hit walls that seemed impenetrable with exposure therapies, cognitive reattribution or any other more traditional CBT. Schema Therapy helps break through the "walls" of shame and fear by offering more than cognitive-behavioral strategies. By modeling and ultimately promoting the constructed enhancement of a healthy adult care-taking mode, changes occur deep at the root of the emotional system. The *healthy adult* facilitates the process of getting the core unmet needs of the vulnerable child (the one who implicitly

Newly Formed: Schema Therapy Association of Ireland

Schema Therapy Association of Ireland (STAI) has been established at an inaugural meeting in Dublin. Several new members attended. There is a growing awareness of schema therapy throughout Ireland and, with the society's launch, the group hopes to serve as a valuable resource by making information about schema therapy more accessible and available to the general public as well as to other

experiences the longstanding shame and/or fear linked with early life issues) met, in an adaptive manner. Self-defeating patterns, and biased emotional beliefs gradually heal as schema links weaken, and become reorganized in the context of healthier and more effective outcomes.

Not surprisingly, people start to feel better physically. Suffering, if not pain, lessens. Symptoms are less frequent. People go back to having more balance…a life worth living.

There are some core profiles of schemas that emerge with most of the patients I have treated with chronic illnesses such as RA, chronic Lyme, HIV, Lupus and the like: Vulnerability, Defectiveness/Shame and Negativity/ Pessimism. These are frequently activated in conjunction with the presentation of a new symptom or sensation in the body. With these patients, it's very important to help them differentiate between schema activation and what are normal and reasonable responses to current and predictable illness-related experiences. Schema mode work can be a critical asset in the differentiating work. The question becomes: *"Is the mode helping or is it creating more suffering?"*

How people cope with illness is often interestingly linked with their coping styles and modes from childhood: Lisa, mentioned earlier, spent hours each day researching new homeopathic or alternative treatments, even right after she just started a new protocol.

She was stuck in an overcompensating mode, very common for people who have suffered and experienced a loss of control over an extended period of time. The modes which tend to be most active in people with chronic illness are Detached Protector and Controlling Over-Compensator; these may show up as substance abuse, shopping, numbing, shutting down, endless research, unhealthy doctor-shopping or insistence on endless rumination about the illness.

As always, it's imperative to take a thorough history because primary schemas and modes that become activated during flair ups are almost always informed by earlier life experiences where schemas and modes formed. For example, Lisa grew up with a highly narcissistic father who had no trust for the medical profession insisting, "doctors poison people". If a person became sick his mantra was, "you should only depend on yourself to get well". If Lisa got sick it was her own fault. So when she became sick all of her schemas and modes became reinforced and highly active, especially since her illness was initially difficult to diagnose. She couldn't trust anyone to help and had to do it all herself, feeling trapped and mistrustful as she was made to feel as a child.

Monica's pain was so intense that she began to shut down as a young child, depending on her fearful mother to take care of her because she could not even walk at times. Her mother was a controlling over-compensator and Monica's pain coupled with her mother's almost constant OC mode resulted in the development of a detachment that was more of a dissociative state, frightening her even further.

The modes that are most active during flair ups, and may prevent the patient from healthily coping with their illness, need to be persistently confronted or there may be little hope of the patient finding adaptive emotional or physical relief. The effect of these self-critical, perfectionistic, detached or dependent modes is the perpetuation of the vulnerable-frightened child reliving early experiences (through their illness) of not getting their needs met ones that could help alleviate some of their current suffering.

For Lisa that could mean trust allowing someone to care for her, and for Monica to feel more of a sense of competency when she is away from her mother. Through imagery and other experiential strategies, in addition to re-parenting and re-scripting, the schema therapist can help patients experience what it would be like to feel better, to depart from their dysfunctional modes. They learn to label the "illness mode" and

dialogue between this mode and others, "*What do other parts say to it? What does the illness say? What does the pain say?*"

Simultaneously, we must be particularly careful to find the balance between time dedicated to meeting the emotional needs of the child while encouraging healthy alternatives in mode coping and decision making regarding medical care and health preservation. Modes, especially avoidance, will fight hard for sustenance acting as *protectors*. And, while thoughtful time is sometimes necessary for good medical care to be rendered, avoidance and detachment need to be differentiated from careful scrutiny and appraisals of health care providers.

We must be particularly careful to find the balance between time dedicated to meeting the emotional needs of the child while encouraging healthy alternatives

Some of our patients who suffer with chronic illness may face other co-existing obstacle in their journey to get their needs met. Some family members, practitioners, even friends may eventually develop compassion fatigue with your highly avoidant or help-rejecting patient; while others or may find the illness an opportunity to control your patient or to feel needed. Doctors who become frustrated when illness is complex and diagnoses are not easily configured can be sometimes guilty of suggesting, "it's all in your head" thus invalidating the patient and perhaps activating core schemas and maladaptive responses.

Mode dialogues and imagery are important and vital strategies for linking the patient's schemas and modes with the "obstacles" that occur during diagnosis and treatment phases related to chronic health issues, keeping the patient consistently and keenly apprised of what they are up against; strengthening healthy responses to implicit and explicit (harmful/hurtful) inputs from others past and present; while also reducing anxiety, hopelessness, and unwarranted fears. In so doing, our patients with chronic health issues can get the care they need…and have a life worth living

Recent Book/ Chapter Schema Therapy Releases

Schema Therapy with Couples: A Practitioner's Guide to Healing Relationships (2015) Simeone-DiFrancesco, C., Rodiger, E., Stevens, B, Wiley.

Good Enough Parenting: An In-Depth Perspective on Meeting Core Emotional Needs and Avoiding Exasperation. Lewis, J. & Lewis, K. (2015), Morgan James Publishing.

Schema Therapy in Dermatology

Dr Alexandra Mizara *BA (Hons), MSc, CPsychol, DPsych, UK*

Skin disease is common, affecting approximately one quarter to one third of the UK population and represents the most frequent reason for people to consult their general practitioner[1]. Despite their prevalence, the majority of dermatological conditions are often considered as 'cosmetic' or 'non-life-threatening' by the general public and the profound psychosocial impact that skin disease may exert on those affected is not often recognized.[2] The role of psychological (di)stress in the onset, exacerbation and perpetuation of symptoms in skin diseases such as psoriasis, atopic eczema, acne, vitiligo, alopecia is now well established.

The experience of the adult dermatology patient varies a lot. Some individuals may be relatively unaffected by widespread disease, while others can be devastated by a relatively small lesion.[3] People with skin conditions often report having difficulties with their interpersonal relationships such as forming or maintaining intimate relationships due to fear of rejection. Social situations are also frequently perceived and cited as problematic. Having a skin condition adversely affects quality of life. Avoidance of activities where skin is revealed such as using the gym, holidaying in climates where minimal clothing is required or other leisure activities is common. Frequent hospital visits and time consuming medical treatments have also been identified as key concerns for dermatology patients.[4]

As well as affecting psychological and social functioning, there is significant psychiatric morbidity associated with skin disease. It is well established that anxiety and/or depression affects at least 30% of dermatology patients and when untreated impacts adversely on the outcome of standard dermatological therapies.[5] Skin conditions such

Announcement- 2016 International Society of Schema Therapy Conference Vienna, Austria

The ISST board is very pleased to announce the 2016 Conference "What is it With Modes" to be held in Vienna, Austria on June 30 - July 2 2015 at the Messe Wien Exhibition & Congress Center.

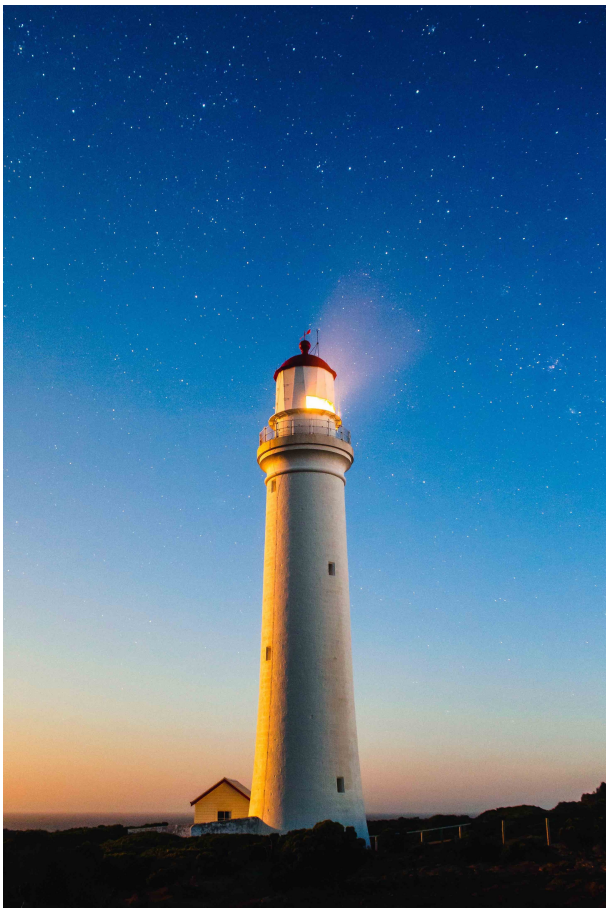
The conference will be the focal point of of schema therapy practice and research and will host a number of key note speakers from around the world.

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

as psoriasis, atopic eczema, alopecia areata, acne and chronic idiopathic urticaria are frequently associated with major psychiatric disorders and there is strong stress-related neuroimmunomodulation that may affect the course of the disease. Some of the most common psychiatric disorders present in these clinical populations are: major depression, obsessive-compulsive disorder, social anxiety, body dysmorphic disorder, eating disorders and personality disorders such as borderline, narcissism and histrionic.

Exploration of the psychological and social factors that make a person more emotionally vulnerable and contribute to poor adaptive coping with relation to skin conditions has led to increasing research in the area of psychodermatology. The presence of characterological profiles among people with skin conditions has been supported by a few well controlled research studies which found that certain dermatology patients exhibit higher levels of alexithymia, neuroticism and difficulty in managing anger and hostility.[5] For example, Picardi and colleagues (2005) suggested that alexithymia is often observed in people with psoriasis and might increase susceptibility to exacerbations of diffuse plaque psoriasis, possibly through impaired emotional regulation.[7]

The role of maladaptive schemas in our understanding of dermatology patients is relatively novel. In a pivotal study, the presence of maladaptive schemas and their links to psychological distress in patients with psoriasis and atopic eczema were examined. Findings suggested that Early Maladaptive Schemas (EMS) are associated with psychological distress in patients with psoriasis and atopic eczema. Six predominant



EMS were identified: emotional deprivation, social isolation, defectiveness /shame, failure, vulnerability to harm and subjugation. Two EMS predicted psychological distress: vulnerability to harm and defectiveness/shame predicted anxiety and vulnerability to harm and social isolation predicted depression.[8] A recent study, investigating the presence of EMS and parenting experiences among individuals with early and late onset atopic dermatitis, demonstrated that people with atopic dermatitis present with a certain pattern of early parenting experiences and a schematic profile that differed them from the control group. The pattern of early parenting experiences was linked to the development of the schematic profile.[9]

The findings in these studies are suggestive that Schema Therapy may be relevant to the treatment of distress in people with skin conditions. Schema Therapy's (ST)[10] effectiveness in addressing complex and chronic presentations, longstanding difficulties in maintaining and achieving satisfying relationships and above all it's compassionate and humane approach sits well with this population. In particular, schema-focused therapy has been successfully used with individuals with psoriasis, atopic eczema, acne, rosacea and urticaria pigmentosa.

Cognitive, behavioural and experiential interventions are employed to achieve the following treatment goals:

- to understand that the skin condition does not dictate life (choices) rather the maladaptive schemas do.
- to heal maladaptive schemas and meet core emotional needs

- to improve relational patterns e.g. problems in personal, social lives and daily functioning.
- to change avoidant coping, either behavioural or emotional and learn healthier ways of coping with the skin condition and other life events.

A lot of emphasis is placed on experiential work and the therapeutic relationship as a means of behavioural and emotional change as affect has a key role in psychoneuroimmulogical nature of these skin conditions. The sessions are individually designed to meet the needs of the patient and no rigid protocol is followed but rather a framework of ST combing flexibility with standardisation is used.

Schema Therapy appears to be effective in achieving substantial change and improving adjustment in people with skin conditions. Our initial outcomes support the relevance of schema therapy for dermatology patients. Addressing maladaptive schemas in dermatology patients enables people to find more adaptive ways of coping and relating to others, and consequently less susceptible to psychological distress. Further controlled, interventional trials are needed to confirm findings in real life clinical practice and to further characterize the role of schema-focused interventions in people with skin conditions.

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Public Affairs Corner-ISST Board Public Affairs Coordinator Travis Atkinson

It has been nearly a year now since the new ISST website launched, and we have successfully enrolled nearly 80% of members on both the website and new listserv. We want to make sure you're getting the most out of your membership, and one area that shines as a benefit is the wonderful work Chris Hayes and Lissa Parsonnet are doing assembling insightful articles published in the Schema Therapy Bulletin (STB).

In addition to the STB, make sure you are taking advantage of several other features as an ISST member, including:

1. **Member Forums:** many special interest topics exist, including a new forum for therapists using schema therapy with the aged, hosted by Bruce Stevens. Visit the Forum section of the website to join now.
2. **Author a Blog:** one of the best things you can do to increase your visibility is to author a blog on the ISST website. The ISST website is highly visited, and has excellent search engine optimization, making a blog authored by you a great resource to drive visitors to your own website.
3. **Istanbul Conference Videos:** we have a large lineup of videos from the 2014 ISST Istanbul Conference, so if you are an enrolled member of the website, you can access them at your convenience.
4. **Research Blogs:** Eshkol Rafaeli has assembled some fantastic blogs from leaders in the research and science area of schema therapy, all available on the ISST website. Read the latest blog on how depression affects the schema therapy treatment of personality disorders.
5. **Call for Submissions:** the Inspire 2016 ISST Vienna Conference will take place June 30 - July 2, 2016, with the theme "What is it with Modes?" We have invited submissions to present using various methods. Read more about these options on the website, and submit your ideas before the deadlines.

Schema Therapy In Medical Settings

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