SCHEMA THERAPY WITH NON-ROMANTIC RELATIONSHIPS

Susan Simpson and Lissa Parsonnet

We hope that everyone enjoyed the amazing 2020 ISST Virtual Summit that took place on May 28-30th! There was a fantastic line-up of virtual workshops and presentations, on a range of topics. A real highlight was the appearance of Dr. Jeffrey Young who was able to provide two workshops. The whole event was a real credit to conference committee and in particular Travis Atkinson, who put an enormous amount of work into making the event run so smoothly, and even organizing virtual social events for the evenings.

We are excited to bring you this latest edition of the ISST Bulletin, focused on Schema Therapy with Non-Romantic Relationships. Notwithstanding the exponential growth of innovations in Schema Therapy for couples, there have also been considerable developments recently in working with relationships of all kinds. Arguably, the notion of building relationships and connections is at the very heart of Schema Therapy.

Martine VanderLaan, in her article" Friend of Foe?: Cognitive interventions to help patients form more positive and stable friendships" describes the mechanisms that contribute to ambivalence in friendships and the role of maladaptive schemas and modes in intensifying these patterns. She describes the 'Friendship Flower', a cognitive tool to help adolescents and adults to explore and enhance friendships.

Christof Loose and Maria Galimzyanova, in their article "Schema Therapy focused on Parent-Child Relationships" explore the influence of schemas and modes within parent-child relationships, and make recommendations on how best to enhance these relationships in schema therapy.

Wendy Behary and Michael Watkins, in their article "Why Leaders do the Dysfunctional Things they do" explore the way in which maladaptive schemas and modes can undermine the effectiveness of those in leadership roles, and suggest new ways in which organizational relationships can be enhanced through the application of schema therapy principles.

Mary Guiffra, in her article "Healing Relationships with Traumatised Modes", she explores the role of trauma in driving divisions and disconnection in relationships, and provides guidance on healing trauma-driven schemas.

Finally, Jeff Conway and Manolya Aydagul present "The Enmeshment & Undeveloped Self Schema And Conflict in Non-Romantic Relationships". In this article they explore the way in which this schema can lead to conflict avoidance and interfere with intimacy and expression of the authentic self in the context of non-intimate relationships.

And… don't miss Vivian Francesco's interview with former ISST President, and ISST board member, Wendy Behary.

As always, if you have suggestions future newsletter topics, or ideas of articles like to submit please contact us!

Susan Simpson (Scotland)
Lissa Parsonnet (USA)

SCHEMA THERAPY FOCUSED ON PARENT-CHILD RELATIONSHIPS

Christof Loose (Germany), Maria Galimzyanova (Russia)

In Schema Therapy we aim to look beneath the surface of problematic emotions, behaviors or parent-child relationships in order to support children, adolescents, and their families to understand themselves and their difficulties. By understanding a problem's deeper layers, they have a much better platform from which to begin interventions.

Schema Therapy model conceptualizes the interplay between basic psychological needs and temperament, defined in terms of schemas, coping styles, and modes. The main concepts in Schema Therapy are further explained below.

I. Basic needs. Psychological needs are considered to be the basis of our self-experience and the "inner driving force" for human experience and behavior. Chronic frustrations, such as absence of nurture, abuse or trauma, or a lack of limits are the moderators of risk factors. When there is chronic frustration of needs, risk factors will unfold their pathogenic potential.

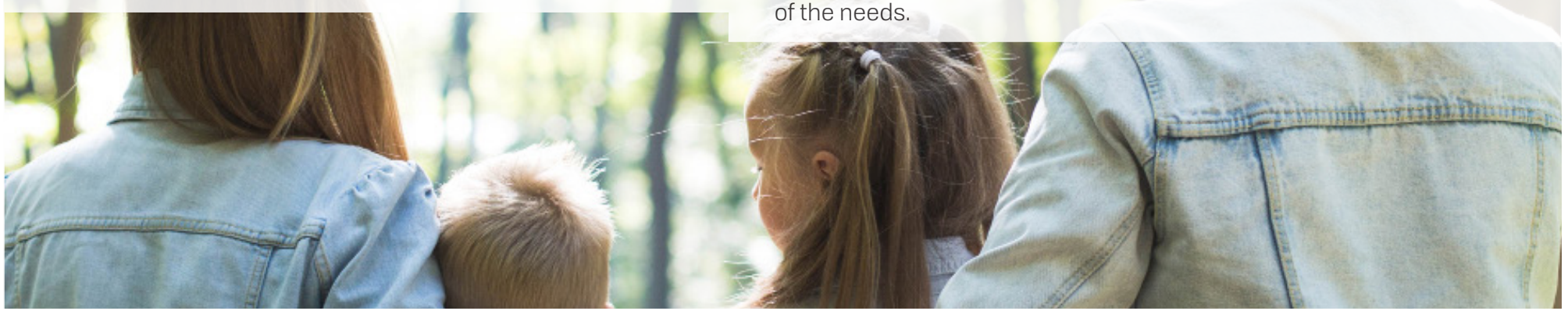
II. Schemas. Schemas develop as both expectations and meanings attributed to experiences (similar to Banduras' low or high self-efficacy beliefs; 1997). Schemas are "a broad organizing principle for making sense of one's life experience" (Young, Klosko & Weishaar, 2003, p., 7). Schemas express relationship to the self and the world.

III. Coping styles. Coping styles are the result of the interaction between modeling, temperamental factors, and operant conditioning; they are individual, and possibly dysfunctional, responses to the chronic frustration of basic needs.

IV. Modes. The development of modes as precursors of personality styles, coping strategies, or characterological habits.

Schema and mode transactional model. The modes or schemas of a "sender" interact with the "receiver". Reactions between sender and receiver impact on each other (e.g. Mode clashes between parent and client)

Most important for an open and good parent-child relationship is the Basic Needs Model, the knowledge what happens when the basic needs are frustrated or inadequately met, and what they can do to avoid frustrations of the needs.



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Basic Needs Frustration model
According to the Schema Therapy model, psychopathology symptoms result from toxic frustration of basic psychological needs (Young et al., 2003). Different authors, including Brazelton and Greenspan (2009), and Grawe (2017), all postulate central psychological basic needs grounded on evolution. Their work has also informed a more accessible model listed below, which can also guide therapeutic focus. This model helps us understand the different levels and facets of needs. The basic bodily needs like physical security (nutrition, sleep, etc.) and physical safety are not listed, although we acknowledge their importance to infant and the toddler wellbeing (and of course, in situations where they are absent there is significant impact).

Figure 1.1 shows our model of basic needs (Loose, Graaf, & Zarbock, 2013); the axis from north to south, the autonomy axis, is central for the healthy development of the child. If basic needs are frustrated, emotions like anxiety, sadness, anger, and shame are elicited.

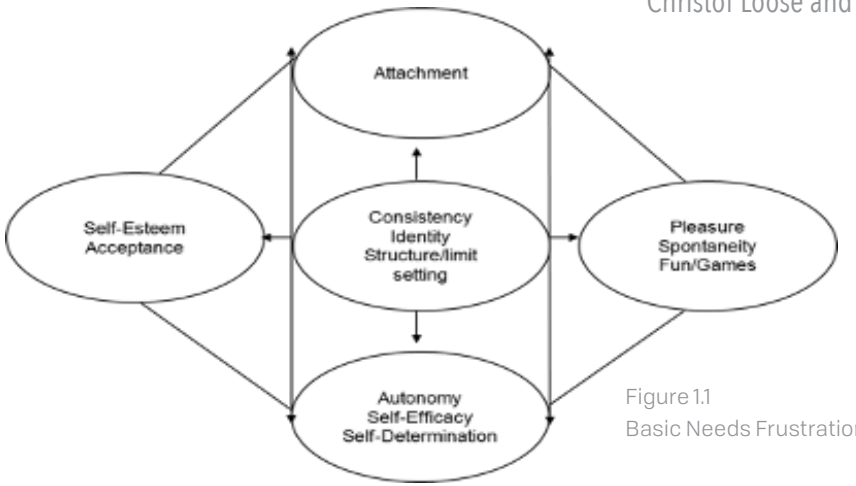

Figure 1.1
Basic Needs Frustration model

The basic needs we list here correspond to the domains listed by Jeffrey Young et al. (2003, see also Roediger, Stevens & Brockman, 2018).

Attachment. Being part of loving relationships and belonging to supportive communities.

Autonomy. Being independent from other's influence, having self-reliance and self-efficacy and the ability to control one's environment.

Self-worth. Being able to appreciate and value self and have self-respect.

Play, joy, happiness, enjoyment, gaining pleasure and stimulation. Being spontaneous and having the freedom of self-expression.

Consistency, structure, orientation. Grawe (2017) postulates an **overarching need for consistency**. Consistency means that the organism strives toward conformity, or consistency between psychological or neurological processes that take place concurrently. One could also view this as a need for **structure and orientation**, in the sense that the environment should be understandable and predictable in order to be controlled. Important to this aspect are **rules and boundaries** in communities. Young and colleagues (2003) highlight that it is a basic need of humans to experience boundaries, structures, and rules.

Parent- and age-specific goals and strategies

In childhood and adolescence, it is generally helpful to think of therapy as systemic therapy, because one can understand the child and the youth best considering the context of the groups the person lives in. The concept of interaction should be expanded using Lazarus' idea of transaction, which makes clear that a behavior emitted from person A elicits a response behavior from person B, and this behavior from person B again elicits a new and answering behavior from person A. It ultimately makes sense to refer to this kind of mutual change, reinforcement, and escalation between individuals and groups – in accordance with Eric Burn's Transactional Analysis (1961) - as transactional rather than simply interactional, because interaction implies a one-sided influence. The concept of transaction underlines the spiraling nature of these processes.

In addition to family relationship spirals, there may be specific family trauma, such as parental conflict, witnessing domestic violence or the separation and divorce of parents, which may result in increased feelings of guilt and shame for the child. In this context schema dispositions may be established and/or already-rooted schema dispositions further deepened.

In general, Schema Therapists can help parents to understand the development of maladaptive schemas using schema coaching or systemic approaches within a Schema Therapy framework. The therapist can teach parents what successful coping and adequate co-regulation for each developmental task can look like. Incorporating positive psychology, the therapist can work with parents to increase protective factors, resources, and positive schemas like self-efficacy. Using a systemic perspective, therapists can also analyze how dysfunctional boundaries in the family system (for example too rigid, too open, family rules that are too inflexible or too broad) may be contributing to the development of maladaptive schemas (like Enmeshment/ Undeveloped Self, Entitlement, Self-Sacrifice, Abuse/Mistrust).

The Importance of Parent Involvement

We insist on the parents' active participation in ST work. They are involved in Schema coaching and actively participate in the child's treatment. Parental contribution increases therapeutic efficiency. According to R. A. Gardner, exclusion of parents from the treatment may become a source of irritation and alienation in parents and favor harboring negative distortions and misinterpretations about the therapist. In turn it often causes premature termination of therapy. On the contrary, direct work with parents provides them with opportunities to express their feelings, disappointments resentments, ask questions. Moreover, anything that can improve the relationship between the therapist and the parent is likely to strengthen the tie between the therapist and the child. (Gardner R.A., 1999)

Sometimes it happens that parents being motivated and full of hope while bringing their child to therapy, later leave, quit therapy, become offensive towards the therapist and show resistance and opposition. It often depends on how the first session was organized and how the therapist treated the initial requests of parents on the first meeting. Also to some extent it may depend on personal reactions of the therapist to so-called "difficult" parents. Some of them can activate strong emotions and trigger the therapist's own schemas. It's very important how the therapist understands the parents' feelings, underlying needs and recognizes the dominating modes.

It's important that in the beginning of schema therapy parents and the child meet with the therapist separately. Presence of the child during the "complaints" of the parents hardens establishing initial contact, prevents developing trustful relationship with the child, causes child's doubts in effectiveness of the therapy, and for the therapist it becomes a hard task in terms of limited reparenting.

We collected most common examples of how parents "set the goals" and behave at the beginning of ST work and linked them to their underlying modes, feelings and needs.

Parents who demonstrate cooperative behavior usually establish good therapeutic alliance from the beginning, try to understand their children, support them, meet their needs. Also they are usually eager to study the ST model and take effort to change the situation and their own behavior. Certainly therapists like to work with them, but they come to therapy quite rarely.

Table 1. Parents' typical behavior at the beginning of ST work, their underlying modes, feelings and needs (developed by M. Galimzyanova, P. Kasyanik, E. Romanova)

Modes/ Coping styles	*Kind of Behavior*	*Manifestations*	*Feelings behind Goal*	*Underlying Needs*
Healthy Adult, Loving parent	Cooperative	Cooperative behavior, good therapeutic alliance, understand and support their children, meet their needs, study the ST model, take effort to change the situation and their own behavior	Love, compassion, interest	Attachment, trust, understanding, mutual support, to form healthy, fulfilling relationship with their child.
Avoiding	Escaping: "I have no time"	Don't participate, hardly appear in the therapist's office. Child is usually accompanied by nannies, grandparents, uncles, etc.	Fears of criticism, connection/rejection	Connection, acceptance, healthy limits
	Shifting responsibility to the therapist	"I told you everything. Now it's your turn...". "You are a specialist and you know better.."	Fears of responsibility, failure Fatigue	Safety, support and self-confidence
	Childish, immature: Hints, omissions, winks, childish behavior in presence of a child	"We both understand what I need..", "You know what I mean..."	Fears of: openness, own immaturity	Self- esteem, the need to accept own inner child, sense of identity
Surrender	Hopeless, Helpless, Self-blaming	" I don't know what else I can do" "It's all my fault and there is no remedy"	Dissatisfaction with own competencies, feeling of guilt because the child is in treatment, Lack of confidence in own abilities	Validation of feelings, consolation, hope, guidance, self-confidence, self determination, sense of identity
	Doubting, pessimistic	"Is it possible to change anything at all?"	Despair, hopelessness, panic Fear of change	Acceptance, guidance, understanding what is happening
Over compensative	Demanding, overcontrolling	Telling the therapist what to do with the child. Demanding concrete results. "You should do "this" and "that" with the child"	Fears of: loss of control, incompetence, insolvency	Safety, connection, spontaneity healthy limits
a) Actively participating , but dictating their terms	Dissatisfied, critical, bullying	Trying to find the reasons to blame the therapist. "Therapy is not working". "My child is still not getting A-s at school"	Fears of: failure, incompetence, insolvency	Acceptance, connection, healthy limits
b) «As if» Cooperative	Manipulative, prying out the secrets	"You will talk to him and then tell me..."	Fears of: intimacy, close contact, rejection	Trust, acceptance, connection, sharing inner experience
	Attention seeking, in search of consolation and support	"Imagine how bad I feel and how hard it is for me ..."	Loneliness Fear of rejection	Need to feel important, to be accepted

Validation of the feelings and underlying needs of parents

Parent's coping strategies make it difficult to switch from complaints about child's behavior to admitting own difficulties and feelings of the parent. Reformulating the initial parents' requests into ST treatment goals becomes much easier if we start with validation of the feelings and paying attention to the modes and underlying needs of parents. Projective techniques may help to bypass the coping modes more easily.

After initial individual work with children and parents separately we can invite children and parents together for joint sessions. It usually helps both parents and children to hear and understand each other better. Playful interventions are widely used in order to help to structure the communication between parent and child so that everyone can feel heard and understood. First of all it's very important to teach children and parents to play peacefully and have fun together. Playing therapeutic board/card games meets the need for Play, Spontaneity, Stimulation. ST Board Game (Journey Through the Modes Valley) is used to help parents and children to learn more about each other, give support, have fun, understand the modes better, bypass the Coping Modes, disempower Critical Modes and to strengthen the Happy and Wise/Clever mode. In the joint sessions "Mode Toy Teams" help to learn about the modes of each other. Parent's and child's modes get acquainted and interact with each other. The toy of the therapist acts as a mediator, facilitates positive mode change and performs limited reparenting.

Some other examples of the playful interventions are: paintings /maps of feelings, mode masks, mode role plays, family memories treasure box, anger venting games ("Snowballs", "War of Pencils", "Pillows Fight", "Angriella" etc.).

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Working together with parents and children can become a very deep and rewarding experience.

Large parts of the article's content and wording are taken from many preliminary discussions and publications around ST-CA. The complete volume will be published soon (about September 2020) with the title: Schema Therapy with Children and Adolescents, Pavilion UK, Editors: Loose, Graaf, Zarbock, & Holt.

THE ENMESHMENT & UNDEVELOPED SELF SCHEMA AND CONFLICT IN NON-ROMANTIC RELATIONSHIPS

In this article we will focus on the Enmeshment & Undeveloped Self Schema from the perspective of how it complicates the handling of conflict in non-romantic relationships. First, we will provide a brief description of how the Enmeshment Schema is developed and experienced. We will then address the ways in which the Enmeshment Schema and the Modes that perpetuate this Schema make the experience of conflict in relationships highly anxiety provoking and therefore, often avoided.

The Enmeshment/Undeveloped Self Schema is a potent Schema that, like all Schemas, is often triggered in the context of interpersonal relationships. Although the complications of enmeshment can be most profoundly and intensely felt in intimate and romantic relationships (Adams, 2011), this Schema can also be experienced in an uncomfortable way in all non-romantic relationships.

One way to consider how this Schema can impact relationships is to look at how conflict in relationships is experienced and addressed. Conflict is inevitable in all relationships and, from a Healthy Adult Mode perspective, although sometimes unpleasant, it can be an opportunity for understanding, compassion, and resolution. In contrast, for a person with a strongly felt Enmeshment & Undeveloped Self Schema, conflict in relationships portends no such possibility.

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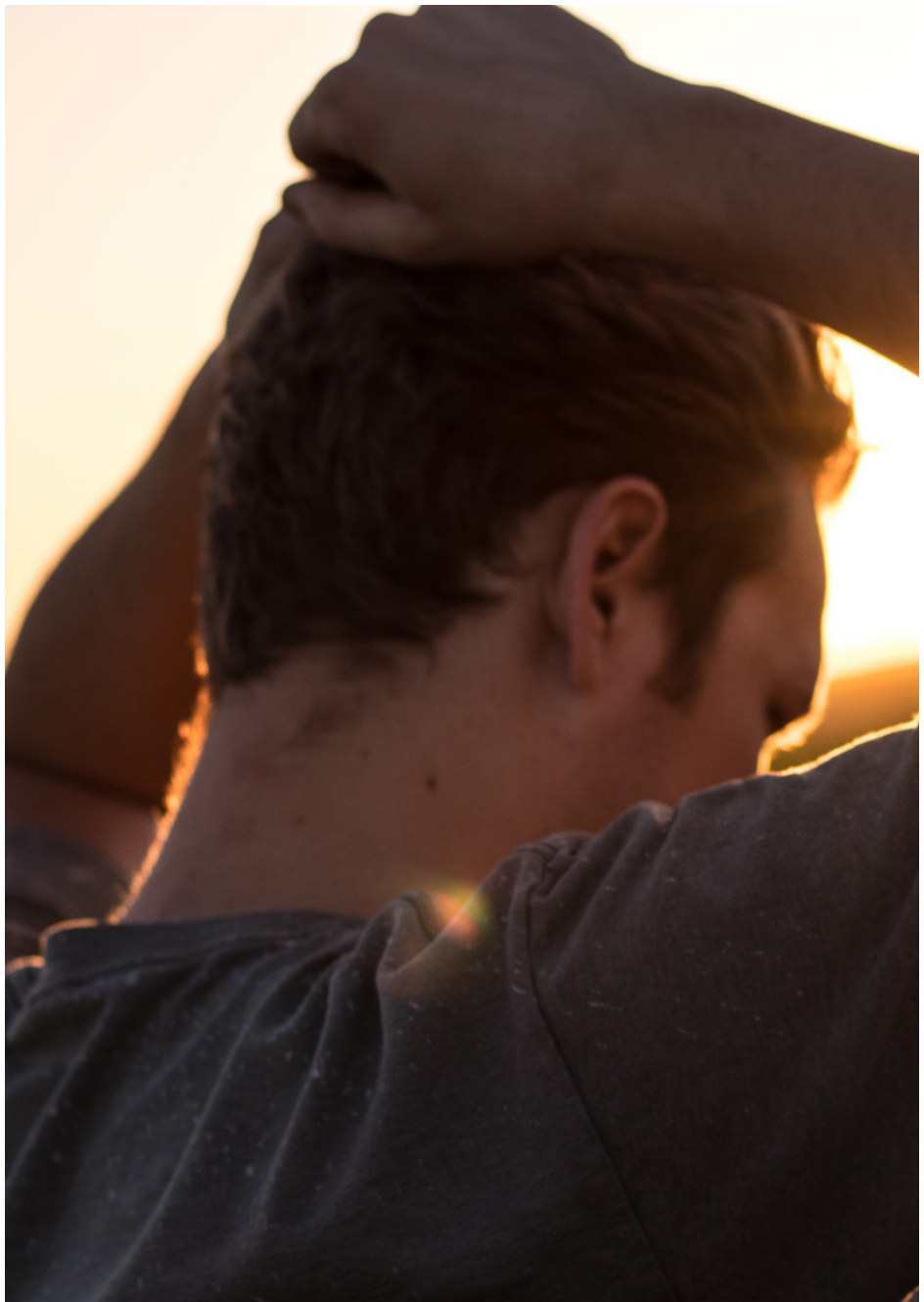
Jeff Conway, MS, LCSW (USA)
& Manolya Aydagul, MD. (Netherlands)



What is Enmeshment

Although it might not be as commonly encountered as Defectiveness/ Shame or Emotional Deprivation Schemas, The Enmeshment & Undeveloped Self Schema is a powerful Schema that many people experience as a source of fear and confusion. It is an unconditional Schema that undermines a person's ability to feel safe and secure within oneself and complicates the forming of nurturing and reciprocal relationships.

To review, Jeffrey Young in his handbook 'Schema Therapy' (2003) defines Enmeshment and Undeveloped Self Schema as "Excessive emotional involvement and closeness with one or more significant others (usually parents or partners), at the expense of full individuation or normal social development. Often involves the feeling that one or both of the enmeshed individuals will not survive or have a reason for living without the constant involvement of the other. May also include feelings of being smothered by or fused with others or insufficient individual identity. Often experienced as a feeling of emptiness and floundering, having no direction, or in extreme cases questioning one's existence."

Like all Schemas, this Schema is engendered in childhood and adolescence. Usually the development of this Schema involves a parent who makes implicit and/or explicit demands on the child to attend to the parent's needs while demonstrating less interest or inclination to attend to the needs of the child. In this scenario, the parent's needs are pre-eminent, and the child is put into roles in the family system which are designed to serve the needs of the parent (Love & Robinson, 1990). The most typical role is the child as a surrogate caregiver or spouse. In this role, the child is attending to and listening to the emotional complaints and needs of a parent, taking on caregiver's tasks, like nurturing younger siblings, and being a strong responsible child who poses no burden for the parent. But there are other roles which circumvent important needs of the child and also foster the Enmeshment Schema; such as the trophy, in which the child is groomed to be an object of pride for the parent while the parent ignores or refuses to consider the interests, wants, needs and aspirations of the child.

A Schema Mode perspective is that the Happy Child Mode has not been allowed to sufficiently develop and the Vulnerable Child Mode experiences a sense of self that is overly dependent upon the requirements of a Demanding Parent Mode ("You need to be there for me; you need to agree with me"). Coping Modes (Compliant Surrender, Detached Protector) conspire to undermine self-reflection and squelch the importance of valuing one's needs and inclinations. Underlying this mode pattern is an Enmeshment & Undeveloped Self Schema which leads to trigger-events in relationships that are experienced with a high level of anxiety and confusion.

In terms of basic needs; autonomy, attunement, and spontaneity and play are not adequately met. The child learns to be overly preoccupied with the other and this preoccupation eclipses self-exploration, self-understanding, and self-advocation. As Virginia Satir (1983) expressed: "Feelings of worth can flourish only in an atmosphere where individual differences are appreciated, mistakes are tolerated, communication is open and rules are flexible – the kind of atmosphere that is found in a nurturing family". That kind of atmosphere does not exist in the enmeshed family system in which the child is heavily imposed upon and actively discouraged from developing a separate voice. And it is in this environment that engenders the Enmeshment & Undeveloped Self Schema and the Modes that insulate and perpetuate it.

Jeff Conway, MS, LCSW (USA)
& Manolya Aydagul, MD. (Netherlands)

Conflict and avoidance of conflict

Addressing conflict in a relationship is a challenge for many people (Botvinik, 2007). In the therapy room, comments like "I'm conflict avoidant" or "conflict averse" or "I just don't like conflict" are typical. The general surface reasons for this discomfort with conflict are "it makes me nervous" or "nothing good comes of talking about conflict" or "people say things they regret." Many people would like to leave it at that and move on to a new topic. But there are deeper reasons for discomfort with conflict, and one plausible explanation for some is the activation of Enmeshment and the Undeveloped Self Schema.

Some of the words associated with conflict are disharmony, antagonism, incompatibility, and opposition. Conflict usually contains a difference of opinion related to a decision or to how one would like to be treated. In a "here & now" experience of conflict, such emotions as anxiety or frustration are experienced and the person's views and opinions about the actual reasons behind the conflict, although not fully formed in the moment, are often not adequately expressed.

For a person with a high Enmeshment Schema, the existence of differences and disagreement in a relationship can be a trigger for a great deal of emotional distress. There is an urgent sense, informed by Enmeshment, that differences are a threat to the security of the self and the well-being of the other. The mere hint of differences can stir a disproportionate level of anxiety and confusion. Conceptualized from the Vulnerable Child's Enmeshed experience, the threat of differences amplifies a sense of identity confusion and exaggerates the perception of peril for the other. From the Enmeshment perspective, the remedy for this perceived threat is being in complete alignment with the other to fortify one's identity and keep the other safe. Being "one and the same" is tantamount to achieving harmony within oneself and within the relationship.

But to achieve this kind of alignment or symmetry, there must be a heavy focus on how one "should" be as opposed to how one "wants or needs" to be. Much has been written on the toxic potency of the word "should". Across the spectrum from Cognitive Behavioral Therapy to Psychoanalytic Models, the crippling power of the internalized rigidity of an imperative has been vaddressed. CBT writer David Burns (1992) wrote of the demand statements as a common error in client's thinking that is a chronic source of emotional distress. Karen Horney (1993), an innovator in psychoanalysis came up with the phrase "the tyranny of the shoulds" to describe the crippling power of deeply internalized demands. From the perspective of Schema Therapy, these inflexible "should" requirements are operationalized in a couple of Modes that serve to perpetuate the Enmeshment & Undeveloped Self Schema.

Mode activation in the Enmeshment pattern

A common Mode that is activated in this kind of situation is the Compliant Surrenderer Mode. This is the mode that "gives in" to the other. Although in this mode the person is reacting against personal interests and inclinations, it often appears to the other person that the person is complying because he/she is sincerely aligned and in agreement. This would leave the other person to believe that they think and feel similarly on the subject and then there is no need for further discussion. The Enmeshed person in the Compliant Surrenderer Mode might in the moment think the agreement is sincere, but usually upon reflection may realize that it was actually Compliant Surrenderer Mode that basically followed the "go along to get along" strategy. The adoption of this mode leaves them feeling unheard, not understood, often frustrated and eventually resentful. This experience of not authentically expressing oneself and therefore not being understood builds a kind of interpersonal wall between the Enmeshed person and the other, that can be indiscernible at first but grows thicker and more obvious with every Compliant Surrenderer Mode episode. The issues that appear to be agreed upon are not as settled as they appear and are more likely to be reneged on in the future. This person often withdraws and shifts into a Detached Protector Mode. And while the Compliant Surrenderere and Detached Protector Modes do provide temporary relief from a conflict in the relationship, they undermine the possibility of creating deeper understanding and connection and sow the seeds for future discontent.

Another mode that can be activated by the Enmeshment Schema is in the opposite direction of the Compliant Surrenderer Mode is the Demanding Parent Mode. In this Mode, the other is required to comply with the point of view and decision of the person in the Demanding Parent Mode. At this point, we acknowledge differences of opinion about whether being dominant or demanding towards another person is a Parent Mode or an Overcompensating Mode (Self-Aggrandizer or Bully Attack). Because this point is not the aim of our discussion here, we want to note this difference of opinion and will continue to refer to this Mode as the Demanding Parent.

In this Mode interaction, the person in the Demanding Parent Mode is commanding that the other submit to this person's perspective. Although the person in the Demanding Parent Mode is taking a quite different behavioural stance than someone in the Compliant Surrenderer Mode, both Modes could very well be driven by the Enmeshment & Undeveloped Self Schema. When the enmeshment schema is triggered, acknowledging differences and working toward a compromise that may serve both people creates an intolerable anxiety. Such an approach would be more likely if both players were in the Healthy Adult mode.

Instead in these Modes, compelled by the Enmeshment Schema, an agreement is made by total submission (Compliant Surrenderer) or imposing a non-negotiable imperative (Demanding Parent).

Enmeshment and Undeveloped Self Schema in friendships

The best of friendships are built on the foundation of mutual understanding and respect, including a respect for differences. But when the activation of the Enmeshment schema leads one friend to enter either the Compliant Surrenderer or Demanding Parent mode, it becomes impossible to reach an understanding and resolution of differences. The process of negotiating and compromise is short-circuited, leaving unresolved issues and growing resentment. A foundation built on such Modes in the service of the Enmeshment Schema is not a sturdy one. The depth and commitment of such Modes is shallow and is unlikely to sustain an ongoing friendship.

The Enmeshment Schema Impact on the Parent/Child Relationship

The parent with a high Enmeshment Schema and corresponding Compliant Surrenderer Mode will struggle to set limits for his or her child due to the anticipation of an angry reaction from the child, which could trigger potent anxiety in the parent.

Differences in a child's temperament or interests can trigger anxious feelings too and may cause the parent to shift into a Demanding Mode. In this Mode, differences are intolerable, and a rigid template set by the parent is the rule. In this Mode a parent may coerce a child to conform to the parent's specifications. In this way, the conflict is suppressed, only to be expressed at another time and probably with greater force, and the child's basic needs for autonomy and attunement are neglected.

The Demanding Parent Mode of the parent can impose requirements on the child that do not correspond with the needs of the child. The parent will impose his or her need to confide, complain, and consult with the child without an apparent understanding that this is burdening the child and that this treatment is at odds with some basic needs of the child, especially autonomy. The conflict that this creates in the child and in the relationship is completely ignored by the parent. By behaving in this way, the parent is likely to be instilling in the child the Enmeshment Schema in much the same way that it was engendered within the parent during his or her own childhood.

Enmeshment in the therapist-client relationship

Therapists with the Enmeshment Schema are generally very skilled at attuning to their client's needs. They usually grew up as parentified children and availing themselves to their parents, knowing what their parents needed or wanted for themselves, was honed to perfection. The therapist with a Compliant Surrenderer Mode may have difficulty setting limits for clients who are imposing on the boundaries of the therapist. In this Mode, the therapist wants to avoid conflict in order to keep their clients happy and satisfied (with the therapist). The obvious conflicts of the boundary violations are left unaddressed. As a result of the therapist being in a Compliant Surrenderer Mode, the therapy becomes stuck, the direction and goals are unclear, and the therapist is usually sitting with some form of resentment. The therapy might continue, but without much vitality or depth. A therapist in a Demanding Parent Mode may attempt to indoctrinate clients to be 'disciples' of their own vision, making their clients subservient to the therapist's opinions and goals. In behaving this way, the client's autonomy is undermined as is the development of self. Whatever conflicts that exist in the therapy are 'mowed over' by the therapist who insists that the client simply accommodate to the direction of therapist. The impact on therapy is profound, because usually the client might feel too intimidated or confused to assertively confront the therapist about this conduct. There is an inequality in the relationship and the therapist becomes an authority figure rather than collaborator. Often clients will simply end their work with such a therapist or remain in treatment and suffer the consequences.

How to address conflict from a Healthy Adult perspective

As a person works to heal the Enmeshment and Undeveloped Self Schema, one starts to see that conflict can be an opportunity for making oneself known and understood with a confidence that the issue of conflict could be worked out and a positive outcome is possible. Conflict can still be difficult; it is for most people, but it is less a source of anxiety and confusion, and more of an opportunity to make needs and feelings known and to create a possibility for better understanding, which can in turn lead to a stronger bond and a greater sense of closeness.

From a Schema Therapy perspective, this would usually involve a stronger Happy Child Mode, which has internalised Positive Schemas, such as Emotional Openness, Self-Directedness and Healthy Boundaries/Developed Self (Louis, J.P., Wood, A.M., Lockwood, G., Ho, M-H. R., & Ferguson, E. 2018). Someone with this kind of a Happy Child Mode possessing these Positive Schemas was raised in a way that supported attunement and autonomy and was mostly protected from the cares and concerns of the parents so that childhood developmental needs were generally met to a good degree. This Happy Child Mode and Healthy Adult internally communicate to each other that conflict between two people can be a source or learning and connection and is not an unsolvable crisis for the self and the relationship. This comports with Satir's idea that health in an individual is a movement away from a domination-submission kind of interaction with others, towards an emerging sense of power from within the self, without the exertion of control on the other (Brothers, 2019).

In Schema Therapy we need to support our Enmeshed clients to be more attuned to their inner world, help them express needs and feelings, and help them learn to tolerate and accept their differences from others, including us, their therapists. It is important that we respect conflict in the therapy relationship and value the potential that exists in the working through of conflict. That also often means making space for their Angry Child Mode which holds a great deal of frustration due to years of unexpressed conflict and therefore can be a source of revelation and understanding in a trusting therapeutic relationship in which a therapist is present, attentive and empathic. Finally, it is vitally important to attend to their Happy Child, to help them build and fortify Positive Schemas such as Healthy Boundaries/Developed Self, as well as work to foster a stronger Healthy Adult Mode that stays in contact with the Happy Child Mode. Working in this way will help our clients in many ways, but specifically will better equip them to accept and learn from differences and conflict in the various kinds of relationships they are working to build and maintain and help them feel more secure within themselves and in their relationships.

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FRIEND OR FOE ?

COGNITIVE INTERVENTIONS TO HELP PATIENTS FORM MORE POSITIVE AND STABLE FRIENDSHIPS

INTRODUCTION

Patients with personality disorders often experience difficulties in close personal relationships. This is true for intimate relationships, but forming stable friendships can also be difficult. Maladaptive Schema Modes can intensify the emotional reactions to certain friend behaviours and lead to cognitive distortions. Poor behavioural choices that stem from maladaptive Schema Modes can also damage the friendship.

Even for those who do not struggle with personality problems, relationships with friends can be challenging. In a population of psychology students, 45% of friendships elicited negative as well as positive feelings (Holt-Lunstad et al., 2007). Two thirds of respondents in a poll of approximately one thousand people identified friends as one of the biggest sources of stress in their lives (Flora, 2013).

The negative impact of troubled friendships is not limited to the psychological domain. Blood pressure is higher in people who talk about their problems with friends about whom they feel ambivalent, than in those talking to friends with whom the relationship is positive (Holt-Lunstad et al. 2007). People who have many ambivalent friendships have a higher risk for cardiovascular disease and depression (Bigalow Buschman et al. 2009) and, in women, there is evidence for increased cellular aging (Uchino 2012).

Positive friendships have the opposite effect, they lead to better psychological and physical health. A meta-analysis of 148 studies shows unequivocally that mortality is significantly lower in people who have several good friends (Holt-Lunstad et al. 2010). Because of findings like these, friendship has been referred to as a behavioural vaccine (Sias and Bartoo, 2007).

Researchers studying ambivalent friendships have discovered that certain cognitive fallacies can turn potentially positive friendships into ambivalent ones and that there are barriers that keep people trapped in ambivalent friendships, when it would be in their best interest to end them.

In this paper, I will start by describing the functions that friends fulfil for one another. I will then address the cognitive fallacies and psychological mechanisms that contribute to ambivalence in friendships. Subsequently, I will show how maladaptive modes and the associated schema's can intensify the negative impact of these fallacies and mechanisms on relationships with friends.
The Friendship Flower is a cognitive tool that was developed for use in Schema Therapy with adolescents who had negative peer group experiences (Vanderlaan et al., 2015, 2017). It has since proved helpful in helping adults Schema Therapy patients examine friendship troubles. The Friendship Flower can help patients understand the cognitive fallacies that can turn potentially positive friendships into ambivalent ones. It can also be used to help patients take inventory of their circle of friends and of themselves as a friend, helping them identify issues they may still need to work on.

Friendship functions

The McGill Friendship Questionnaire (Mendelson & Aboud, 2014) lists six functions that friends fulfil for each other. The first is stimulating companionship: sharing fun, enjoyable or exciting experiences. Friends also help one another, they give advice and lend a hand. Intimacy is present when friends are sensitive to each others' needs and are able to express thoughts and feelings openly. Reliable alliance refers to the loyalty and availability of a friend. Self-validation means the friend is reassuring, encouraging, and helps to maintain one's self-image as a worthwhile person. Finally, emotional security refers to the confidence and support provided by a friend in challenging circumstances, when the friend doesn't betray trust, or draw attention to one's weaknesses.
In some friendships all six of these functions are provided, but relationships that offer only a few, or even only one, can be valuable.
If, for example, a friend shares a favourite hobby, that may be enough make the relationship worthwhile.

Cognitive fallacies & psychological mechanisms that fuel ambivalence in friendships

Sometimes it isn't the friendship itself, but the way it is perceived that leads to ambivalence. Faulty ideas about friendship are at the root of this phenomenon.

Rounding is the conviction that a friendship is only good when it fulfils all of the friendship functions (Levine, 2009). A friendship with someone who is understanding and kind when you feel low, but who doesn't like to go out and do fun things, can become ambivalent when this cognitive fallacy is in place.

Related to this is the mirror image trap, where the friend is expected to offer the exact same thing that is offered to them (Flora 2013). A positive relationship in which friends complement each other, can become ambivalent when viewed through the mirror image lens.

Holt-Lunstad et al. (2007) found that a mechanism they call support interference can be particularly damaging. When someone turns to a friend for support, but receives criticism instead, this leads to strong negative feelings. Support interference was found to be responsible for a large part of the detrimental influence that ambivalent friendships have on physical and emotional health.

However, if a friend cannot offer support, this does not necessarily make the relationship worthless. If you stop asking for that which this particular friend is unable to give, the relationship might still be worthwhile and positive, if other friendship functions are provided.

Why do people hang on to ambivalent friendships? Bigalow Bushman and Holt-Lunstad (2009) describe two types of barriers that keep people trapped in toxic relationships. When a friend is part of the same social circle, it is hard to make a clean break. This is an external barrier. People who place great value on loyalty and forgiveness, may find it hard to disengage from a friend. The need to see oneself as someone who has many friends can also make it difficult to end a friendship. These are internal barriers, which according to Bigalow Bushman and Holt-Lundstad, are more important than external ones.

Maladaptive Schema Modes and ambivalence in friendships

Maladaptive Schema Modes can intensify the problems caused by the abovementioned cognitive fallacies. Punitive or Critical Parent Modes can lead to rigid adherence to rounding as well as the mirror image trap, creating ambivalence in friendships that might otherwise be positive.
When a patient has not yet learned that the needs of the Vulnerable Child Mode are legitimate, support interference will be especially painful. The criticism the friend gives instead of support, will trigger the Punitive Parent Mode (you don't deserve support; how stupid you are to think that your stupid needs are worth somebody else's time!). People who blame themselves for the negative feelings caused by the support interference, instead of attributing them to the friendship, are unlikely to consider disengaging from the relationship, so the hurt will keep repeating itself.

Maladaptive Schema Modes can also interfere with the quality of friendship the patient offers to others. When feelings are suppressed by strong coping modes, several friendship functions (emotional security, intimacy and self-validation and possibly help) will be hard to fulfil. Avoidant coping modes will potentially interfere with all six friendship functions, as will Punitive and Critical Parent Modes. Impulsive and Angry Child modes make it difficult to provide reliable alliance. Stimulating companionship requires a reasonably well developed Happy Child and healthy adult modes. Finally, mode flipping can be extremely damaging to every type of relationship, including friendship.

The Friendship Flower

When a patient who has some understanding of Maladaptive Schema modes talks about something a friend has said, done, or failed to do, the Friendship Flower shown below can be a useful tool. It can be used to analyse the problem in terms of friendship functions and cognitive fallacies.
The first step is to explain the various friendship functions, which are included in the Friendship Flower. Subsequently, it can be used as a work sheet, with the patient writing the name of their friend next to the functions that he or she provides. Usually this will show that although the friendship causes stress, there is also some good in it.

Next, the therapist will suggest that the friendship in question may be an ambivalent one, and explain that this is a very common phenomenon. This will help alleviate some of the pain the patient suffers due to Schema Modes triggered by the conflict.
The cognitive fallacies that taint potentially positive friendships are explained, again referring to the Friendship Flower. The patient is asked to examine his or her friendship trouble to see whether one of these fallacies may have played a role in creating it.
It is especially important to make sure the patient understand the concept of support interference, since it is responsible for a lot of the damage caused by ambivalent friendships, which can be repaired if this mechanism is understood. When a patient complains about a lack of support from a friend, useful questions are:

- Were you clear about what you were looking for when you talked to your friend?
- Which Schema Modes are triggered when your friend criticizes you instead of offering support?
- Has your friend failed to support you on other occasions?
- Would it be possible to discuss what happened with your friend and if so, does his or her behaviour change?

If the friend is unlikely to be able to change, the therapist can help the patient evaluate whether or not the friend offers other friendship functions that make the relationship worthwhile.
Once a patient understand the mechanism of support interference, this can lead to liberating changes in the friendship, as well as other relationships as well. When the patient stops asking for what the friend is unable to give, he or she may go on to discover the wat support interference also plays a role in the relationship with a parent or co-worker.

An important point to make when discussing problems with friends is that it can sometimes be okay to withdraw from a friendship when the ambivalence remains strong. Discussing the types barriers that keep people trapped in ambivalent friendships will then be helpful.

When the problematic friendship has been dealt with, the Friendship Flower can be used to help the patient take inventory of their entire circle of friends and acquaintances, by writing names next to friendship functions. This helps identify those friends that are safe to turn to when support is needed. By taking inventory of their social life in this way, patients often discover that their friendships offer them more than they thought.

As a final step, the patient is asked to examine him or herself as a friend. Which friendship functions to they offer to others? A reverse Friendship Flower is used to visualize this.

If a patient discovers that they have trouble fulfilling certain friendship functions, this can point to Schema Mode work that remains to be done.
Awareness of the ways in which maladaptive Schema Modes and mode flipping impact their friends, can help the patient take responsibility for their own role in creating problems in the relationship. When they open up to their friend and acknowledge that there are issues they need to work on, the friendship will have a better chance of surviving and becoming a positive part of the patient's life.

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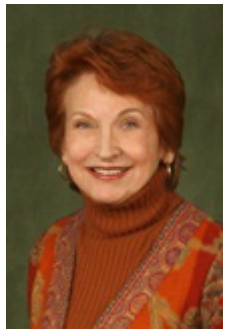
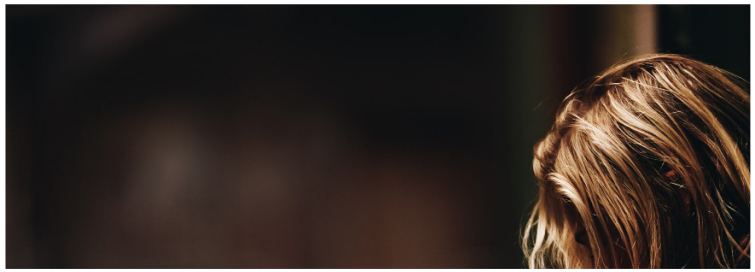
HEALING RELATIONSHIPS WITH TRAUMATIZED MODES



Ever wonder why it is difficult for some people to relate closely to certain friends, teachers, colleagues, employers or loved ones? As Schema Therapists, our first thoughts revolve around Early Maladaptive Schemas, Core Emotional Needs, Schema Modes and Maladaptive Coping Styles. Perhaps frozen trauma is another variable in building the wall that separates them? Is the trauma hidden behind Schemas, Modes or Maladaptive Coping Styles?



Integrating concepts from Peter Levine's Somatic Experiencing into Jeffrey Young's Schema Therapy. I am hypothesizing that one reason we have difficulty developing relationships with colleagues, bosses, family members and friends is because of unprocessed frozen trauma. It is deeply embedded in the nervous system and may underlie schemas, modes, unmet needs and coping styles. Adaptive coping styles are often learned in families of origin, schools, play groups etc. it follows that maladaptive coping styles may be influenced by trauma in the family of origin. Strategies to slowly and mindfully release the trauma and freeze are clarified later in the discussion. (Levine,1997, 2015)

In a recent article of Psychology Today, (5/7/20), Albert Wong describes "Why You Can't Think Your Way Out of Trauma." He explains that CBT has been the standard of care for the last 30 years. The mindfulness revolution has expanded the intervention. Dr Wong clarifies that cognition and behavior remain in positions of primacy. However, advances in neuroscience challenge the completeness of that belief.

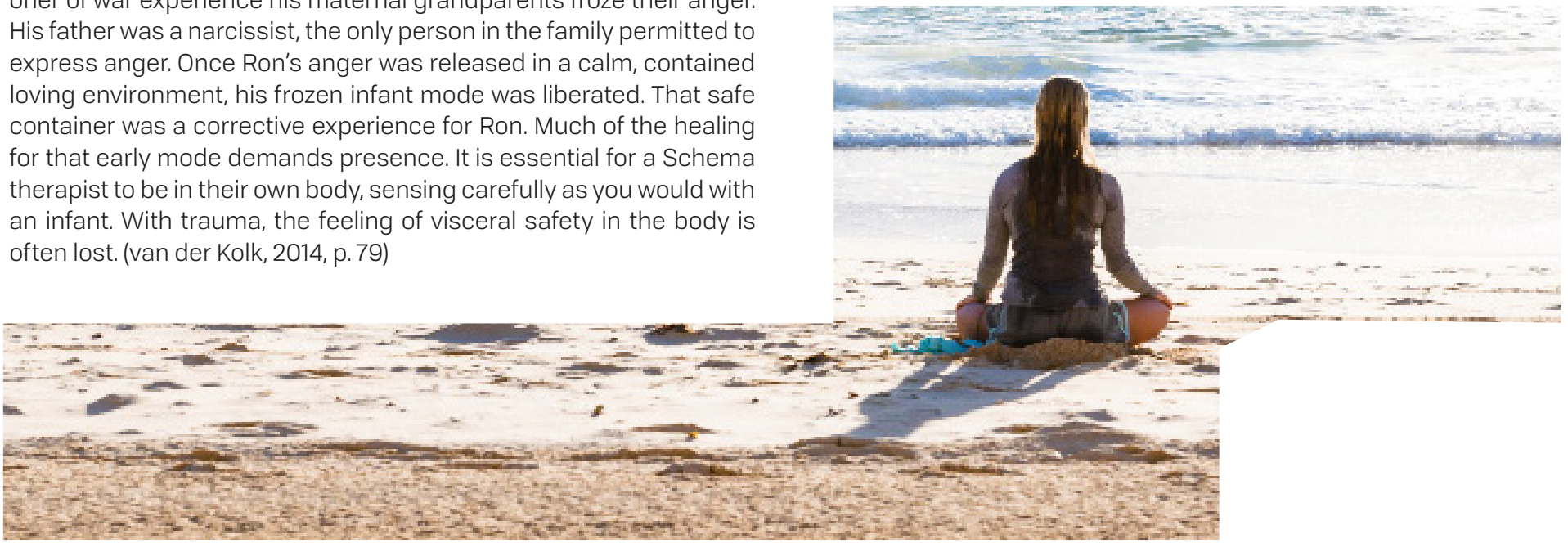
Trauma is an experience that overwhelms the nervous system. Levine emphasizes that trauma is not in the event. It is in the body. Whether an upsetting event becomes a trauma or PTSD depends on a variety of factors: intergenerational history such as war and abuse, racism and poverty; divorce and sexism. Early medical procedures; death and illness; previous traumas; attachment history and individual resilience impact outcomes. Trauma can occur as early as prenatal life when the nervous system lacks myelination, a protective insulation against stress. Consider the role of the nervous system and the body in attachment.

We know an attached parent when we see one. The way they hold their child, their warmth and comfort with touch. How they connect and respond when the infant or child, gets angry or needy. They may do beautifully with an infant yet have trouble with a toddler or teen. Conversely infants may terrify them. Suspect trauma in their background.

I had a client, a professional person with a doctoral degree. As we did mode work and he tracked his body sensations, images came up. Ron got in touch with his angry child as a toddler. For the first time in his life he could feel. It grounded him. He loved expressing the anger as he felt alive. Prior to that experience, Ron felt as if he was floating in space, a terrifying experience. Existential terror, fragmentation, rage and shame are common to pre and perinatal trauma.

Ron's grandparents were former prisoners of war. His parents were intellectuals, concerned with education and discipline. They did not connect physically or emotionally. No holding, no hugs. They parented him the way they were parented. Ron's vulnerable infant mode appeared after his angry child expressed anger, aliveness and a sense of grounding to mother earth. As a result of trauma from the prisoner of war experience his maternal grandparents froze their anger. His father was a narcissist, the only person in the family permitted to express anger. Once Ron's anger was released in a calm, contained loving environment, his frozen infant mode was liberated. That safe container was a corrective experience for Ron. Much of the healing for that early mode demands presence. It is essential for a Schema therapist to be in their own body, sensing carefully as you would with an infant. With trauma, the feeling of visceral safety in the body is often lost. (van der Kolk, 2014, p. 79)

The essence of trauma is an overwhelm of the nervous system. The input is more than a person can process and their window of tolerance is shut. The most corrective experience for traumatized early modes is to regain the experience of physiologic safety with another person. Hence the Schema Therapist who provides the corrective experience of presence provides a calm loving container for the young mode to experience that safety. You can teach the healthy adult how to do that when a mode is triggered.



Back to physiology and infant trauma. Myelination of the fatty sheath insulates the neuron from intense electrical charge. This neuronal myelin sheath increases the efficiency of electrical transmission from the body to the brain and the brain to the body. Increasing myelination of the nervous system allows the child to do more, to move and turn, to crawl and stand. It is completed by the end of the second year. Afferent transmissions begin in the body and go to the brain. Efferent transmissions then exit the brain and return to the body (Baars & Gage, 2012)

Compare myelination to the electrical tape you wrap around damaged wires to prevent shock. An example to demonstrate lack of myelination occurs when you accidently bump a newborn's crib. The infant responds with a severe startle. It is an instinctive response called the Moro Reflex, a predictor of normal development. Holding the baby close, swaddling him, supporting his head and neck or gently holding baby's arms and legs close to his body like a hug can be calming to a startled infant. You can also teach the healthy adult how to soothe their traumatized modes.

Have you observed patients in your office as their Modes exhibit a startle response? Slow down and create a calm, loving, non-demanding corrective experience as befits a startled infant. Startle response can occur throughout life. It is a defensive response to sudden or threatening stimuli, loud noise or sharp movement.

When relating to modes with early trauma, in addition to strong presence in your own body, you explore bodily sensations of the young mode. In terms of cognitive development, it is called the sensory-motor phase. When relating to a child mode be effective. Avoid using adult theoretical formulations. Adult developmental theory does not suffice for a child going through cognitive developmental phases of sensory-motor, magical thinking or even concrete thinking. Young modes are not abstract thinkers. (Piaget, Child's Conception of the World,1951). You approach the healthy adult with adult developmental cognitive and behavioral concepts. It is not effective when you are relating to a child mode especially one who is traumatized (Corrigan & Hull, 2015).

How does a Schema Therapist develop a relationship with a traumatized mode? Use your senses. Be curious and teach the healthy adult to be curious. Remember and sense - if you can - an earlier time when you felt stumped or perhaps immobilized. Maybe you wanted to fight back or flee and instead your Protector shut you down. Wisely! Back then, it might have been unsafe to fight back or to flee from the situation at home, school or in the community. Detached Protector shut the window on those instinctive responses to keep you safe. Honour the wisdom and loving protection in that shut down state. Try to experience safety in this moment.

Dr Wong notes: "One of the most useful models for understanding trauma comes from Peter Levine's conceptualization of the constituents of phenomenological experience that he has memorialized in the catchy acronym, SIBAM and his work of Somatic Experiencing." (Wong, 5/7/20, p-1) Allow a sensation, image, behavior, affect or meaning to arise as you focus on safety or a pleasant experience. If you are patient and your detached protector senses safety; you will naturally move to the trauma or freeze triggered by the challenging relationship. It is a pendulating motion from resource to trauma and back to resource. Imagery re-scripting can be healing for the infant and young child mode if it evolves from the work and the schema therapist or healthy adult provides corrective experiences.

Once your patient starts to experience the least discomfort, track it in his body, notice images that come up, bodily movements or emotions that occur. Schemas develop from the meaning a mode gives to those SIBAM experiences. Remember to begin with safety and resource. The body will naturally go to the trauma once a container of safety is established. The goal is to slow down the experience. Titrate it so the vulnerable child mode has a chance to process the experience slowly and gently in his young nervous system. The initial trauma was a result of overwhelming the young mode's nervous system. Take all the time you need. Slower is faster and less is more. (Levine, 2015)

No need to dig. It is an organic experience. Slowly support the person as a skilled parent or healthy adult would do. If that parent or healthy adult had been present and supportive at the time of the initial trauma, it could have been processed on the spot. The attached and present parent might have been a container of safety for the vulnerable child. Instead the orienting or fight/flight responses were frozen in the young body and the imprinted trauma is now interfering with current relationships.

We recognize that frightening, rejecting, shaming or painful events, falls or scary experiences are part of life. The outcome depends on the support of a nurturing parent and or the presence of a healthy adult. Trauma is not in the event. Rather it is held in the body through unexpressed and frozen fight/flight physiologic responses. The more previous unprocessed traumas experienced, the deeper the freeze.

Avoid digging deeply to connect with the traumatized mode. Be present. Let your intellect be curious and simply observe. Allow the subcortical brains - where the trauma is imprinted - to take over. Those subcortical brains have been handling life threatening trauma in the wild for eons.

Animals in the wild experience trauma daily. Wild animals go after them. They fight back or flee. If overtaken, they will fall. Blood leaves the periphery, goes to the core of their body and they freeze. The animal on attack sniffs, assumes they are dead and goes in search of live prey. The frozen animal gets up shakes their body eliminating the adrenalin created and goes about his day. If the attacker decides to have him for lunch, the freeze response becomes nature's anesthetic. In contrast the traumatized child mode has embedded the freeze or frozen fight/flight modes for a lifetime, interfering with relationships each time any of the SIBAM components are awakened. (Levine. 1997)

Remember that the smart human brain and healthy adult may or may not have been on- line when the freeze of the detached protector initially appeared. It depends on the intensity of the original shut down, past traumas and the degree of support in the early environment. Spend some time helping the person to feel safe. Enquire as to any fears.

Labeling a fear reduces intensity for the mode and tends to bring the healthy adult back online. Ask the healthy adult to create space for a new experience to occur; not one colored by schemas, cultural or family conditioning. Be curious as you allow a novel response to the old trigger, stimulus or schema.

Leave plenty of space and allow all the time needed to identify the missing piece.
With traumatized modes, slower is faster and less is more. Be aware that the healthy adult is smart and quick as well as caring and kind. It seeks causes and solutions and wants to know and place experiences in categories that give us a sense of control over our environment.

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In contrast, traumatized modes are operating at earlier levels of cognitive development. They may experience the world strictly on a sensory level. Or they might use magical thinking to make sense of the overwhelm. As a child gets older, thinking becomes rigid. People - including modes- are good or bad right or wrong. Abstract thinking is the foray of adolescent and adult modes and influence the schemas that develop later.

That caring detached protector inside saved you from experiencing pain too intolerable to process back then. Be gentle and respectful of the protector modes. They shut down the physiologic and emotional overwhelm that might have immobilized you.

Ideally, it is the parent's job to lovingly sense the young child's upset; support, calm and sometimes distract that young child from overwhelming sensations. However, if the parent never experienced that kind of parental support and no teacher, therapist, family member or friend ever healed their wounded place, how can they be present to frightened or abused child modes?

Advice gurus and psychotherapists coach us to connect with lovers, partners, friends or family members. Psychoeducation and CBT helps. Sure, there are cultural, religious, gender and racial values and expectations that can be clarified.
But when you experience a real shut down and a wall against connection, deeper work is needed. Be curious! Look behind the schema or the wall between people. Use the above strategies to thaw out the mode and express the underlying trauma that is interfering with daily relationships at work, in community, within nuclear and extended family.

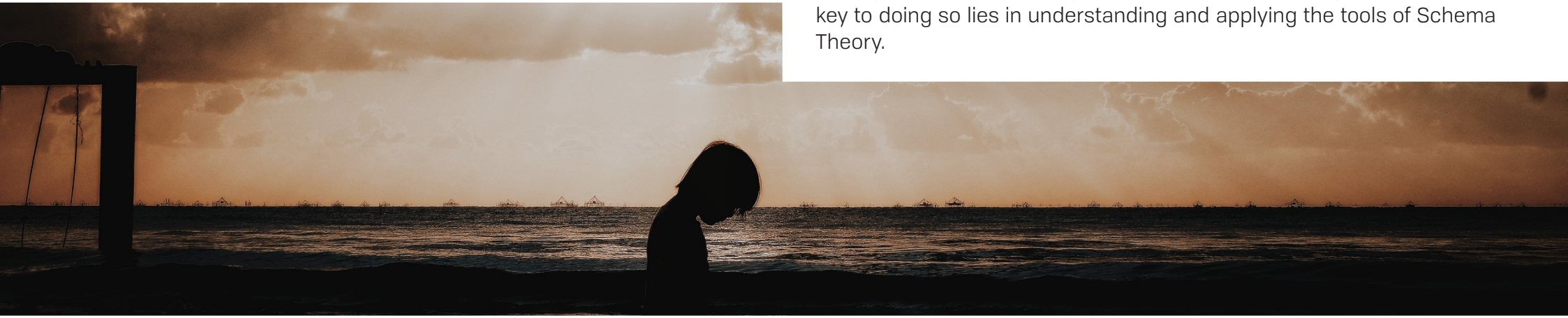
Why Leaders Do the Dysfunctional Things They Do

Early in a meeting to discuss marketing strategy, Daniel, the VP of marketing interrupted his CEO, Paul, who had launched into a typically long-winded explanation of why his view of the way forward was the right one.

Pausing to shoot a disapproving look at Daniel, Paul pushed on as if nothing had happened. Visibly wounded, Daniel sat back in his chair, mumbling an apology and looking resentful. Reading the reaction among the rest of his executive team and feeling he had contributed yet again to causing an uncomfortable scene, Paul directed dismissive comments at Daniel, casting responsibility for this "unhelpful interjection" onto him. Daniel responded by defensively trying to rationalize his decision to introduce the new data, only to be cut off and told to "stick to the agenda." The meeting ended with everyone in an unsettled state and little accomplished.

In our work with top executives and their teams, we often observe scenes like this and listen to our clients recount them. These sorts of unproductive interactions are both common and damaging. In the case of Paul and Daniel, both emerged from the meeting angry and resentful setting the stage for further strife between them and lost opportunities to move the business forward.

Why do poisonous dynamics like this take hold? In many cases, it's because leaders and their subordinates are locked in the grip of maladaptive emotional patterns that, when triggered, show up as dysfunctional modes of behavior. Even the best leaders sometimes can fall into these derailing modes of leadership, especially when under stress. Only by understanding these patterns and learning to identify and manage them can they hope to lead and follow more productively. The key to doing so lies in understanding and applying the tools of Schema Theory.



The Schema Theory framework

Schema Theory is the conceptual foundation of an integrative school of psychotherapy, developed by Dr. Jeffrey Young and his colleagues in the early 1990s, and practiced around the globe. It combines elements of cognitive behavioral therapy (which focuses on correcting biased beliefs and altering self-defeating behaviors) and interventions focused on healing early emotional trauma. Extensive research has established its efficacy with some of the most difficult-to-treat psychological syndromes, such as personality disorders and chronic mood disorders, such as depression and obsessive-compulsive disorder.
It also turns out to have profound implications for understanding why dysfunctional leaders do the things they do.

Where do these deeply rooted patterns – called maladaptive schemas – come from? In most cases it's from early experiences of not having basic needs met. Every leader once was a child, and like every child depended on others to get basic needs for safety and attachment met. When those needs were not met, for example through abuse or neglect, or when getting parents' attention or approval depended on behaving in specific ways, for example being perfect at doing things, getting high grades at school, or winning at sports, then very deep patterns of behavior get established. Early experiences of abuse, for example, understandably result in a propensity to be mistrustful, and constant pressure to perform can lead to a need to be perfect.

Schema Theory and leadership

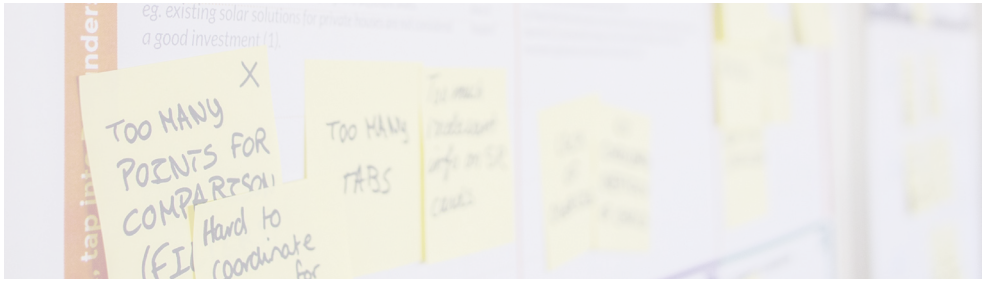
The importance of Schema Theory in understanding and shaping leader behavior resulted from early conversations we had about the challenges Michael [Watkins, one of the authors] was facing in coaching some senior executive clients.
For this subset of clients, conventional coaching methods failed to have a positive impact because of what appeared to be deeply ingrained patterns of dysfunctional behavior. While these leaders responded somewhat to feedback from psychometric or 360 assessments, they ultimately seemed to be unable to realize more than temporary change. Helping them seemed to be more the province of therapists than executive coaches.
At the same time, a substantial subset of Wendy's clientele were people in senior leadership positions, although they often entered therapy because of serious issues in their personal lives such as divorce or estrangement.
In our conversations, we explored the intersection of our two professional worlds and the potential for Schema Theory provide insight into dysfunctional leader behavior and new strategies for executive coaches.

Maladaptive behaviors

Ultimately, we concluded that many executives operate in the "shadow" of their early maladaptive schemas in ways that profoundly undermine their effectiveness as leaders. For Paul, the CEO, his volatility and bullying behavior left everyone who worked for him "walking on eggshells" and unwilling to challenge him, even when it was clear he was wrong. For Daniel, our VP of marketing, his constant need to seek recognition and approval prevented him from "showing up" in a more powerful and effective way.
This has very important implications for the behaviors of leaders. When triggered, early maladaptive schemas can cause people to shift into self-defeating modes of behavior like those experienced by Paul and Daniel
To explore this further, we began by seeking to understand the prevalence and impact of schemas and corresponding dysfunctional modes of leader behavior.
Based on existing questionnaires created by the practitioners who developed Schema Theory, we constructed a questionnaire focusing on 10 schemas we hypothesized were likely to influence executive leadership.
We sent the questionnaire to a sample of former participants in a 4-week executive leadership program at the IMD Business School, getting 55 responses

	Somewhat True	Mostly True or Completely True	Somewhat, Mostly, or Completely True
Unrelenting Standards	27.10%	46.50%	73.60%
Recognition-Seeking	40.40%	31.40%	71.80%
Entitlement	31.90%	25.30%	57.20%
Insufficient Self-control	19.80%	16.30%	36.10%
Punitiveness	20.00%	15.00%	35.00%
Social Isolation	22.10%	6.90%	28.90%
Mistrust	17.70%	6.90%	24.50%

Do You Have Unrelenting Standards? Click here and find out.



What we found

Analysis of the data showed that the leaders reported significant frequencies for seven of the 10 schemas we selected, as shown in the table below. The schema with the highest frequency as "Unrelenting Standards", with almost 50% of the respondents indicating that it was "Mostly True or Completely True" that they exhibited the associated behaviors.

The "Unrelenting Standards" schema shows up as an internalized "voice," typically reminiscent of a demanding parent, driving those who have it to hold themselves (and often the people who work for them) to impossibly high standards. It may also show up in leaders who were left to fend for themselves as children. Because they didn't get adequate nurturing or guidance, they constructed a hyper-autonomous coping response as a form of survival, vowing never have to count on or "need" anyone.

Dysfunctional modes and triggers

Schemas can lie dormant until they are "triggered" by specific events (sensory experiences, social interactions, the behaviors of others) that lead to their activation. Schema activation triggers a shift from one emotional mode to another, potentially maladaptive one, for example from a calm, encouraging state to a highly demanding state.

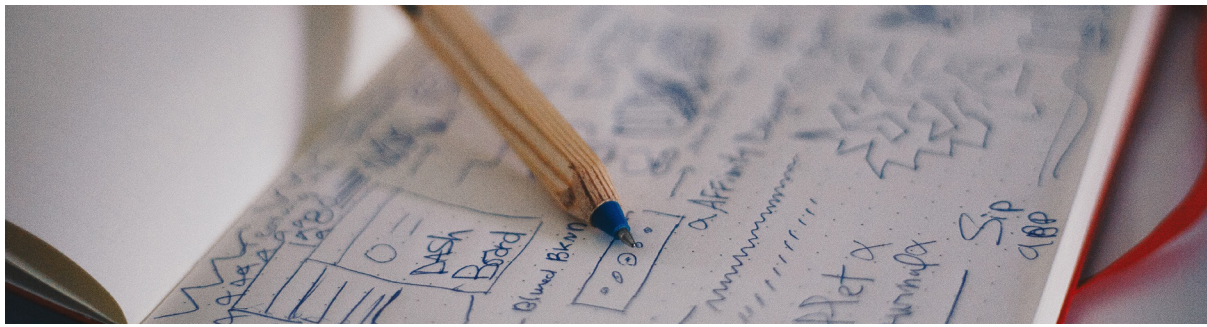
Leaders often have a relatively small set of schemas and a corresponding set of modes through which they shift over a course of time. Paul, our CEO, did have a "Healthy Adult" mode (wise, emotionally accessible, reasonable, rational, thoughtful) in which he operated a significant amount of the time; he also had a "Demanding Parent [Critic]" mode (with unreasonably high expectations and rigid standards) into which he shifted when he thought subordinates where underperforming. Daniel experienced, a third, "Bully" mode in which Paul directed sarcastic, demeaning comments at his subordinates. This mode often is associated with the "Punitiveness" schema, which results from early experiences of being punished for even minor misdeeds. About 15% of our sample of leaders reported it was mostly or completely true that they had the "Punitiveness" schema. In fact, there is a strong correspondence between the seven schemas we identified as most common in the leaders we studied and a corresponding set of dysfunctional modes as detailed in the chart...

Schemas	Dysfunctional Leadership Modes	Common Triggers
Unrelenting Standards The need to meet, and often have subordinates meet, impossibly high standards for performance, often driven by fears of criticism or shame.	The ***Demanding Critic*** who constantly operates in overdrive, places unrealistic or unsustainable demands on themselves and others, and is unable to be satisfied or recognize and celebrate	• Subordinates who don't meet very high standards • Subordinates who are not viewed as working hard enough or being sufficiently committed.
Recognition-seeking Excessive emphasis on gaining attention and approval from others with are perceived to have high status in order to feel a sense of self-worth.	The ***Approval-seeker*** who tries too hard to impress those deemed important or special, sometimes to the point of taking credit not only for his/her own work but for the work of others.	• Meetings with VIP's, such as investors, owners, partners. • Encounters with "special" clients or first-class colleagues. • Being in the company of people with people, title, or a special status.
Entitlement The belief that one is superior to other people; entitled to special rights and privileges and/or not bound by the rules of reciprocity that govern normal social interactions.	The ***Narcissist*** who makes the rules and breaks the rules; who masks insecurities and (often) feelings of inadequacy by acting as if he/she is better than others, and has earned the right to not have to *wait in line* like average folks.	• Being interrupted when speaking • Having to wait for one's turn. • Being inconvenienced. • Activities that generate discomfort or lack of immediate gratification. • Having to listen to someone else for a length of time.
Insufficient Self-control Inability to exercise sufficient self-discipline and to tolerate frustration to achieve professional goals, or to restrain inappropriate expressions of one's emotions and desires, or, in some cases, to manage use of self-soothing	The ***Loose Cannon*** who is volatile, inconsistent and unfocused in pursuing important tasks and following through, and can be offensive interpersonally. Can also become excessively involved in distracting and stimulating activities.	• Challenging tasks/projects that have lengthy and detailed time lines • Having to do routine or boring activities • Being confronted on a missed deadline, or a pending disciplinary action such as being mentored
Punitiveness The belief that oneself (and others) should be harshly punished for making mistakes, even minor ones, often exhibited through anger, intolerance and impatience.	The ***Bully*** who has little to no tolerance for others' errors, missteps, or perceived failings, and who tends to become condescending, degrading, harshly critical, abusive, or threatening.	• Subordinates who miss deadlines • Lateness, even when unavoidable due to crisis or emergency • Misplacement of something, a folder, a phone, an email • Misstatement in a meeting
Social Isolation The feeling that one is isolated from the rest of the world and/or not part of any group of community. Sometimes shows up as feeling different and disconnected	The ***Lone Ranger*** who "goes-it-alone" when it would be better to enlist the collaboration of others. Prefers to remain on the periphery with subordinates and colleagues, observing versus actively connecting or participating.	• Team projects • Networking invitations • Company social events
Mistrust The belief that people will take advantage of you, manipulate you, hurt you, or use you for their own advantage.	The ***Skeptic,*** who is suspicious about subordinate and peers' motives, monitors their activities looking for the smallest signs of betrayal. Distrusts compliments and positive feedback, feeling someone wants something from them.	• Being asked to do/give what feels like "more" than what was agreed upon • Perceptions that others are "ganging up" or conspiring • Praise or compliments • Personal questions

While having one of the seven schemas doesn't guarantee that you will exhibit the corresponding dysfunctional leadership mode, it's likely. If you do, the shift into these modes will happen as the result of specific triggers, which are very important to understand and learn to manage.
Leader's schemas can get triggered by the actions of their subordinates – which can be the result of their own schemas and modes getting activated. The result can be in "schema clashes" that can be highly damaging.
Daniel, the marketing VP, had a "Recognition-seeking" schema, which he acquired because he only got attention as a child when he "performed." When triggered, this schema shifted him to an "Approval-seeker" mode of behavior in which he tried too hard to impress people in authority. About 31% of our leaders reported that this pattern of behavior was mostly or completely true for them.
When the desire for recognition from Paul activated Daniel's "Recognition-seeking "schema and he shifted into "Approval-seeker" mode, it triggered Paul's "Punitive" schema and shifted him into a "Bully" mode, with unfortunate consequences for both of them.

Maladaptive schemas are common

Our research revealed that most executives have one or more early maladaptive schemas and corresponding dysfunctional modes of leader behavior. This does not mean, however, that all leaders need therapy. For those whose schemas run deep and whose modes are highly damaging and difficult to control, it may help. In fact, we have had some tremendous successes working together as therapist and coach with the same clients.
However, for most leaders, it's enough to work with an executive coach who is versed in Schema Theory and can help them to understand and manage their dysfunctional modes. This starts with an assessment done by a coach who understands the framework and employs supporting diagnostic tools. Once identified, the focus of the coaching is not on healing the underlying schemas; that is the work of therapists with in-depth training. Coaches focus helping the client to 1) understand when and how dysfunctional leadership modes get triggered and 2) learn to anticipate, avoid, and mitigate their impact on one's leadership.



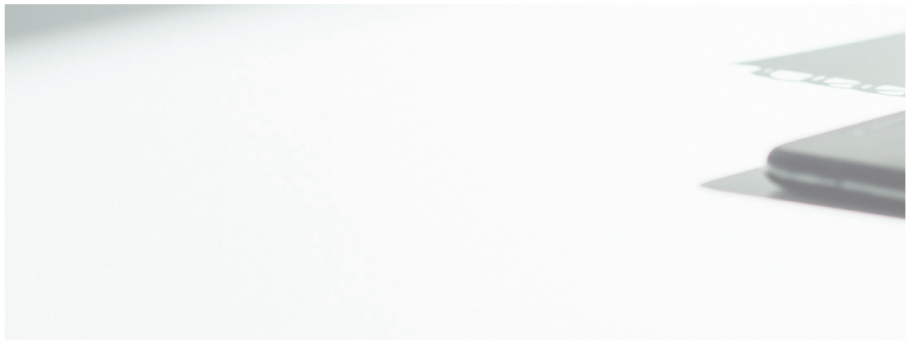
Where to start

For leaders like Paul, for example, who have a "Demanding Critic mode that that stems from an "Unrelenting Standards" schema, the starting point is to recognize that the mode exists and explore how it impacts their leadership. When you are in the "Demanding Critic" mode, how do you feel and what behaviors show up in your leadership?
Once awareness is raised, the next step is to recognize how (and how often) the mode gets triggered. What are the circumstances that lead to the mode-shift from "Healthy Adult" to "Demanding Critic"? How often does it happen and what are the implications when it does? Understanding of the frequency and intensity in which this mode shows up offers important insight into the nature of the work to be done. If the mode is frequent, intense and highly

Coaching preventive action

Assuming this is not the case, however, and armed with insight into one's dysfunctional leadership modes, the coaching work can proceed to anticipation, avoid and mitigate them. The coach works with the leader to help them build their awareness that a shift into a dysfunctional mode is in danger of occurring. This is a big step in its own right. While it is important progress to understand one's modes and recognize that they have been triggered after-the-fact, the mode shift still has occurred and some damage has been done. It's another big step to develop anticipatory awareness that a mode shift is about to occur and to take preventive action.

Taking preventive action means developing strategies to avoid and mitigate the impact of mode shifts, such as diversion, disengagement, and delay. Diversion essentially means trying to change the subject. If there are topics or behaviors that one knows are likely to trigger a dysfunctional mode, one can try to shift the conversation or do something to break the frame of what is happening. Failing this, disengagement can be a strategy worth trying. This can range from, "I need to take a break" to, "I can't discuss this at all further right now." Finally, when one is triggered, it can help to try to pause, breathe, and delay the resulting reaction. We believe, for example, they every leader should have a folder of "emails I wrote, but didn't send."



Developing the ability to anticipate, avoid and mitigate one's dysfunctional leadership model doesn't heal the underlying schemas: the propensity to get triggered, shift into a dysfunctional mode and react in potentially damaging ways remains, but becomes more manageable and less damaging.

For leaders who decide to go down the therapeutic, schema-healing road, with or without the support of a coaching partner, the benefits can be great. To do this, however, we have found they first have to overcome a basic barrier: the fear that doing this work will make them less effective as leaders. This is particularly the case for executives with the most common of the schemas: "Unrelenting Standards." Leaders with this schema believe that perfection is the key to success, even survival. So, it's natural for them to feel that the alternative to achieving perfection is mediocrity, and that ceasing to strive relentlessly for perfection will lead to failure.

The good news is that the executives with whom we have partnered have become more effective leaders, not just people who are more satisfied with their lives. The alternative to unrelenting standards is not no standards; it's high-but-achievable standards. And the alternative to the pursuit of perfection is not mediocrity, it's striving for excellence.

*N.B. This article was previously published at TLNT https://www.tlnt.com/why-leaders-do-the-dysfunctional-things-they-do/

INTERVIEW
with Wendy Behary

It is an honor to interview you, Wendy, as you are an important role model in the Schema Therapy Society. This is a very threatening time in which we all share feelings of vulnerability amid such a sense of uncertainty and isolation. Wendy, perhaps you can weave somewhat of a tapestry surrounding these feelings as they relate back to your own experience with isolation and profound schema triggering… tell us a little bit about yourself.

As many of our members already know, I was dealing with a serious illness at the end of 2018 into early 2019 which necessitated my living in isolation due to a compromised immune system for 6 months of treatment. Isolation and vulnerability can certainly arouse our most challenging feelings and our worst fears. I think the experience of coping with all those frightening triggers gave me some "pre-training" for the COVID-19 pandemic. I am so grateful to my ISST friends and colleagues for such undaunting support, love, prayers, and thoughtfulness during a very difficult time for me. I am happy to report that I have been in remission now for almost 18 months.

Probably my proudest role as an adult is that of being the very lucky mother of a beautiful, wonderful human, my daughter Samya! This has been one of the greatest privileges and delightful roles in my life. I am also a proud professional integrating the role of therapist, author and teacher. I never dreamed that my book, Disarming the Narcissist, would become an international bestseller and be translated into 14 languages.

I feel like being an educator is a really core part of who I am. (I can also be a bit of a drama queen and people know this about me in my teaching role.) I love public speaking and that really goes back to an early avocational life in drama and theater. I had a lot of fun training as a performer since I come from a family whose members were actively engaged in the theater. I dabbled in community theater when I was much younger and participated in tap dance and vocal arts allowing me the good fortune of getting really comfortable with the stage and the microphone. I also have a strong maternal family background which has served as a sturdy role model for me.

Where did you get your early training?
It was never my intention to become a therapist. I started my training in college in advertising and marketing. A lot of people know me as the queen of promotional campaigns. I love to campaign and help other people get things off the ground as well as my own projects. I switched to a sociology/psychology major at some point in my university days. Truth be told, I had a crush on my sociology professor but primarily, I just found it so incredibly fascinating to look at systems and how things work. The human condition and how we are put together has always intrigued me. I was originally going to continue my studies in organizational psychology as I was fascinated with the world of work. That was my original thought. Many people along the way including my mentors, professors and friends would say "You know, you should be a therapist. You've always got interesting advice and insight." It really didn't appeal to me so much at first although I was admittedly really motivated by

my experience as a "survivor" of Catholic School in the 60's. I was fascinated by deviance, dominance and controlling behavior because the nuns were so brittle and abusive. As a result, most of us learned how to be a "good soldier". Actually, students were highly compliant because it was a dangerous place. I always say "survivor" because I feel like most of the reconciliation of my schemas comes out of a reawakening to the origins which, as we know, can also evolve from the school environment. We can't forget how important the influence of school settings can be on the origination of schemas. I did go on to get my degree and ended up becoming a clinical psychotherapist /clinical social worker.

How did first learn about schema therapy?
I went to Rutgers University right here in New Jersey. It was a wonderful faculty at the time so I was really fortunate. I had already finished my Bachelor's degree in Psychology and Sociology so I continued and received my Master's degree in Clinical Social Work. It was the fastest track and I knew all along that my most important training would come after graduate school…
My interest in Schema therapy dates back to when I attended the Love Is Never Enough conference at Columbia University with Aaron Beck and his daughter Judy Beck. All of a sudden, Dr. Beck introduced this young psychologist Dr. Jeffrey Young who had created this new wave of Cognitive Behavioral therapy called Schema focused CBT. The moment he started talking, I found myself "bedazzled"! I was transformed and I knew I had to meet him and to learn from him and so I did just that! I am so fortunate to be able to call him my dear friend for 30 years!
I was honored to be invited by Jeff to early brainstorming sessions in his Columbia University classroom back in the 80's to develop Schema-Focused Cognitive therapy. Starting shortly thereafter, we both remembered fondly the Case Conferences led by Jeff at the Center for Schema Therapy on 80th Street. It was in the early 90's that Jeff developed the mode model for BPD followed by the creation of a mode approach for Narcissism around 1993. I was so grateful to be a part of the early "think tank" for the Schema therapy model. There I made some long term and cherished friends.

What role did you play on the ISST board and what made you want to accept this role? What did you learn from your role?

I was a founding member of the ISST and also the Training and Certification Coordinator from 2008-2010. I was then elected to be the President of the Board of the ISST from 2010 to 2014. I was honored to accept these roles because this afforded me an opportunity to help create greater connections among schema therapy clinicians and researchers across the globe and to continue to promote access to educational opportunities and finally to inspire new and upcoming clinicians to get involved in our ISST missions.

I have also enjoyed being invited to many beautiful cities around the world offering workshops and lectures to the schema therapy community while experiencing the good fortune of meeting some of the loveliest people and talented clinicians who have since become special friends!

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

In the beginning it was just our New York Center; there was no ISST. Once the NYC Center closed Jeff and I began co-directing, what would become, the NJ-NYC Schema Therapy Institutes. We have created an annual International Training and Certification Program to eligible clinicians from all around the world for the past 11 years. Schema Therapy has grown exponentially since the beginning and my hope is that we continue to grow and expand all around the globe. But my personal hope is that we can further our expansion throughout the United States.

Joan Farrell and I are very excited to have recently signed a contract with the American Psychological Association to write the first text book on deliberate practice in Schema therapy for graduate students thereby bringing Schema Therapy into graduate classrooms!

How do you enjoy spending your free time?
Prior to the pandemic, I enjoyed an abundance of fun activities, some of which include my love of playing my djembe drum and "hoofing" which is a hardcore type of tap dancing that I always loved (now a bit more difficult with aging knees). I really enjoy time spent with my family, and splitting our time between our homes in New Jersey and Washington, D.C. We love being in D.C. particularly just exploring the city's rich and diverse culture, the beautiful monuments and sights, as well as great restaurants and theater. I also love reading, taking long walks and going to live theater.

How do you get into your "happy child mode"?
My happy child comes out with music, movement/dance but it can also present itself when I am just being silly with friends, or with my daughter, or my husband. My favorite happy child memory which I will never forget was the ISST conference gala on the boat ride in Istanbul in 2014. I urged Alp to crank up the music and I grabbed Hannah Hoppe and one by one everyone started dancing until we had a whole boat load of "happy child modes" dancing away on the boat! That and "silly selfies" too!

Are there any other thoughts you would like to share with the ISST family?
First and foremost, I miss my dear ISST friends and colleagues. I was so looking forward to seeing everyone at the conference in Copenhagen. But for now, I hope that we will enjoy an amazing Virtual Summit. I am so thankful to Travis Atkinson for his mammoth undertaking and to all of the program organizers and the Executive Board. Hopefully, we will all be together in Copenhagen in 2021! I pray that our schema family will stay safe and well in the meantime…

IMPORTANT DATES FOR YOUR DIARY

Forthcoming ISST Conferences

- ENLIGHT Virtual Conference 2020 – tickets still available for purchase! (recordings will be available through at least the end of May, 2020!)
- Melbourne ENLIGHT conference: postponed (updates to be provided
- Copenhagen INSPIRE conference: June 24-26 th , 2021 (hybrid event - available both online and in-person!!)

ISST Webinar Series (hosted by Susan Simpson, Chris Hayes and Andrew Phipps)

Topic: 'Pushing for Anger in Cluster C Personality Disorders'
- Presenter: Ruth McCutcheon & Saskia Ohlin
- Host: Andrew Phipps
- Date: 30th September, 10:00 UTC, (12pm Central European Summer Time, UTC+2)

Topic: 'Interweaving EMDR with Schema Therapy for Trauma Processing'
- Presenter: Graham Taylor
- Host Chris Hayes
- Date: 1st Dec, 12:00 UTC, (8pm Perth, Australia)

Recently recorded webinars, now available on the ISST website:

- Topic: 'Phase Based Schema Therapy'
- Presenter: Rosi Reubsaet

- Topic: 'The role of the Healthy Adult in Creating Intimacy & Connection'
- Presenter: Tracey Hunter

- Topic: 'Strengthening the Healthy Adult '
- Presenter: Eckhard Roediger

- Topic: 'Transformational Chairwork & the Four Dialogues'
- Presenter: Scott Kellogg

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