THE SCHEMA THERAPY BULLETIN

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Viennese memories.... Schnitzel, Gustav Klimt, Strudel, Sigmund, Beer Gartens, The 3rd Man, Kaffeehause and..... the ISST Inspire 2016 Conference!

The 2016 Vienna Conference set a new standard in the development of the International Society of Schema Therapy. With over 600 people attending the 3 day event, the conference highlighted the exponential growth of the organisation (a far cry from the 35 people attending the inaugural meeting in Stockholm in 2004).

The event brought together researchers, clinicians and students from around the globe to discuss all things schema therapy. The conference also saw attendees from nations as diverse as Indonesia, Mexico, Russia, Iran, Bulgaria and Serbia via support from the inaugural "ISST Ambassador Program." A ISST initiative aiming to financially assist members from developing and evolving countries around the world, who have shown enthusiasm for schema therapy.

This issue of the Schema Therapy Bulletin focuses on a small selection of some of the highlights from the conference. Judith Margolin and Robin Spiro comment on Treating Dissociation: Mode work and Beyond. Sally Skewes (Australia) discusses the development of "Secure Nest" an on-line tool to enhance therapeutic work in Schema Therapy. Kathleen Newdeck (USA) summarises a workshop presented by Jeff Conway and Wendy Behary centring on enmeshment and the undeveloped self. Robin Spiro (USA) summarises Odette Brand and Maria Rocher's presentation focusing on identifying and handling overcompensation modes. Finally, Robin Spiro reviews Wendy Behary's wonderful Vienna keynote address focusing on therapist empathy in treatment.

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

In this October Issue

Treating Dissociation: Mode Work and Beyond

Judith Margolin and Robin Spiro (USA)

Dissociation has been conceptualized as a normal, defensive, survival related response to a severe threat or danger. This mechanism becomes a habitual way of coping under conditions of chronic abuse and relational disruptions. As a result, many chronically traumatized children are unable to develop a unified sense of self across behavioral states, resulting in the development of alternate identities. Similar to schema modes, these organized patterns of thinking, feeling and behaving based on a set of schemas, represent different facets of personality that have not been integrated into a whole. This lack of integration gives rise to a functional dissociative self, with relatively independent schema modes (Arntz, Klokman & Sieswerda, 2005, p. 227). As Young et.al. (2003) stated "the more extreme the dissociative personality, the greater degree of pathology and the more separated maladaptive schema modes are from each other and from healthy aspects of the personality".

During the recent conference in Vienna (June/July 2016), Judith Margolin and Robin Spiro presented the clinical case of "Diane", demonstrating the blend of

Schema Therapy, and the mode model, with approaches drawn from the fields of Trauma and Dissociation. This approach to the Phase Oriented Treatment of a patient with Dissociative Identity Disorder (DID) identified adaptations to ST and the mode model that can be used to effectively enable resolution of trauma.

A phase oriented treatment of DID was presented, highlighting the functions of *mode management* and *mode awareness*. Mode management serves to diminish maladaptive schema and schema modes (alternate identities) by helping alters function in an integrated, collaborative and cooperative manner, and by increasing safety and stability. Risk assessment, grounding and containment are some of the techniques used throughout treatment for effective mode management.

Psychoeducation about DID, and increasing mode awareness helps patients understand the experience of DID in a depathologizing way, recognize that individual alters/parts may have multiple modes, and identify and name different alters and the functions they serve. Different techniques for mode management and increasing mode awareness, some of which were developed by Joan Farrell and Ida Shaw, were noted. These include the Safety Bubble, Circle Monitor, Alter Questionnaires, Mode Information sheets, Alter/Mode Monitoring, and reorganizing alters /modes in order to stabilize the system (Pairing Alters, Grouping and Mapping Alters). As shame is reduced via the limited reparenting relationship and trauma processing, the modes often spontaneously develop cooperative and compassionate internal relationships.

Margolin and Spiro identified particular challenges in working with DID. Extensive dissociation, with larger gaps in awareness and memory, adds difficulty to treatment but can also enable trauma work with an alter, without overwhelming the main personality. Alters are more differentiated, separate and less transient than modes. There is less access to the Healthy Adult. Alters provide a sense of identity, and loss is often experienced with change. As re-experiencing of trauma is more intense, greater rescripting is often necessary.

"Dissociation has been conceptualized as a normal, defensive, survival related response to a severe threat or danger."

The integration of trauma processing interventions, drawn from the trauma and dissociation field, was illustrated. Reframing the apparently punitive parent mode as a protector mode, and aligning with the self-destructive modes/alters were demonstrated as necessary healing interventions. Dissociation as an extreme detached protector needs to be respected to prevent decompensation, and is sometimes used therapeutically via distancing techniques. This enables trauma processing within a window of tolerance. Other techniques, including fractionation and pendulation, were demonstrated, along with methods of mode work for rescripting, with short vignettes from actual sessions with "Diane."

The case of "Diane" demonstrated one of the central trauma healing interventions, limited reparenting. As Richard Chevetz said during his keynote address at this conference, "IT IS ALL ABOUT THE RELATIONSHIP". Being a "good parent", establishing a safe, trusting relationship involves active engagement, providing a therapeutic holding environment, bonding with a system of multiple alters, and open discussion of schema activation within the therapeutic relationship. Limited reparenting is considered one of the most powerful tools to change the maladaptive character of the schemas and to meet the needs of the patient (Sempertequi, et. al., 2013). Developing a limited reparenting relationship with a DID patient is complex and challenging but ultimately rewarding process. Relationships develop differently with the main personality vs. vulnerable child parts and angry protectors, and require a sturdy, consistently caring presence throughout periods of testing and mistrust.

This clinical case presentation clearly demonstrated the bridge between Schema Therapy and the Schema Mode Model, and best practices from the fields of trauma and dissociation in the treatment of DID. As one participant stated, "it was a deep, clear presentation that balanced well between theory and clinical material, also allowing room for short demonstrations of actual sessions".

Secure Nest in Vienna: Enhancing Therapeutic Work Using Technology

Sally Skewes

Australia

From June 30 to July 2, we had the opportunity to showcase Secure Nest (SecureNest.org) for the INSPIRE 2016 biennial conference in beautiful Vienna. It was exciting to participate in a conference which embraced technology, the provision of Wi-Fi throughout the convention centre and a mobile app which kept us informed of event schedules and encouraged connection between attendees was a welcome addition. The ISST community provided a supportive environment in which to facilitate an interactive workshop and present findings of the first research study exploring user experience of Secure Nest.

Developed in Australia, Secure Nest is a new e-health tool which has been specifically designed to complement Schema Therapy. Secure Nest has the potential to enhance therapeutic work by providing a sense of ongoing contact, connection, sharing, and promoting self-expression and autonomy; valuable aspects of limited reparenting which is an essential "active ingredient" of Schema Therapy. Secure Nest provides therapists with the opportunity to meet patients' needs outside of the therapy hour using an online platform.

Secure Nest was developed in consultation with internationally renowned Schema Therapists, who we are grateful to count as our dear friends and colleagues. While the primary language is English, it was recently translated into Dutch and the platform was designed with multi-lingual capabilities with the intention to provide additional translations in the future.

Just as the conference focused on applying the many aspects of mode work in Schema Therapy, Secure Nest is an online platform based on the schema mode model. The

ISST News

Schema Video Toolkit-

a collection of 19 videos of essential and advanced strategies demonstrated by Dr Gillian Heath and Dr Tara Cutland Green, experienced, ISST-accredited trainers.

www.schematherapytoolkit.com/

DVD= Schema Therapy For Cluster C Personality

A 3 disk DVD series aims to provide an overview of the specific methods and adapted techniques that are suitable for treating the Avoidant, Dependent and Obsessive-Compulsive Personality Disorder patients. Resented by Remco Van Der Wijngaart and Guido Sijbers

www.schematherapy.nl

features of Secure Nest stay true to the Schema Therapy conceptual model. For example, 'My Modes' provides an individualised case conceptualisation that the client can access anytime via an internet connected computer or mobile device. The 'Identify My Modes' and 'Mode Diary' features can facilitate mode awareness and reflection in the present moment by providing opportunities for easy identification of modes in the day to day lives of our clients, therefore keeping the modes fresh in the clients' mind. 'Managing My Modes' provides a central location where all exercises and strategies (including audio recordings) can be accessed, for responding to each mode. 'My Goals' provides a visual reminder of the clients' goals throughout the site using a small personalised icon. We appreciated the curiosity and active interest the participants showed at the workshop, in particular with regard to the features of Secure Nest.

We have also recently completed the first pilot qualitative study exploring user experience of Secure Nest. Susan Simpson and Rachel Samson contributed their expertise to the study. We were excited to present the findings in a Hot Topic Talk at the conference.

A growing body of research shows that using e-health tools can enhance outcomes for Borderline Personality Disorder. There are several benefits of e-health tools, including:

- Facilitating the availability and equitable delivery of treatment according to patient need.
- Providing the potential to add significant value to Schema Therapy at a minimal cost.
- Offering a potential solution for reducing the number of face-to-face sessions.

Our study was the first of its kind to explore the qualitative experience of therapists and clients using an e-health tool, which has been specifically designed for Schema Therapy. A therapist focus group and individual client interviews were conducted to explore the potential utility of Secure Nest as an adjunct to Schema Therapy within an outpatient psychology clinic setting. Our sample was mixed, with a predominant diagnosis of BPD and high levels of co-morbidity. Clients started using Secure Nest at varied points in Schema Therapy. All clients used Secure Nest for 12 weeks, alongside a 1hr weekly face-to-face Schema Therapy session. We used thematic analysis to analyse the data and identify themes, which were agreed upon by all authors.

Online Trauma Forum- Get Involved

Following the Vienna conference a new special interest group has been created for clinicians doing trauma focused work.

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To provide a sneak peek into the themes, the qualitative findings show that Secure Nest complements Schema Therapy by:

•Providing a sense of ongoing contact, connection and sharing.

"Oh, it's nice, like connected, warm … that she thinks of me between sessions, to keep that connection going, so when I go away out the door it's not just a polite see you later, she's not like that anyway… but it just gave me more sense that she's gone into the site and logged in and just thought of me to do something and it's very personal stuff in there, so yeah, I felt connected and thought of."

• Meeting patients' needs outside of the therapy hour.

"I can read her Healthy Adult responses and think oh, okay, that's a good way of looking at it … I'm not as distressed for as long because it's before I see her for the next therapy session, It's definitely…a great thing, yeah definitely."

• Facilitating mode awareness and reflection in the present moment.

"If anything it's good, it's a positive because they can really, I mean if you're in, say, having a fight with someone or whatever and then you fill out the mode diary, you know it's very raw and it's exactly how you're feeling so … it can be very much in the moment if you fill out the mode diary then and there, so you can really get exactly how you're feeling."

• Providing ease of access and organization.

"The fact that it's just there, definitely, it's a huge help. Whereas if I had a piece of paper, a pen and filled out the schema diary I'm just not as motivated, I mean, my phone is there and I use my phone so yeah without a doubt if you go to an appointment or do anything you've just got it there with you."

Client concerns were raised with regards to:

• Disclosing sensitive information.

"I think pouring out your heart sort of on the internet and then when you save it it's like it's there isn't it, you can't just rip it up."

• Early maladaptive schemas triggered by response time.

"I guess it can also be a trigger for [me as] a client, only because if the therapist doesn't respond, you [wonder] why they aren't responding..."

The main themes identified from the therapist focus group include that Secure Nest provides a sense of working collaboratively, at inter and intra session level – like a 'joint project.' Therapists reported increased inter-session connection and object permanence, as Secure Nest functions as a transitional object. Therapists observed the disinhibition effect – Secure Nest provides graded exposure to being vulnerable. Secure Nest is helpful for keeping track of large quantities of information, and the conceptualisation is readily available. Therapists reported that using Secure Nest requires familiarity with technology.

The findings indicate that Secure Nest adds value to therapeutic work by enhancing limited reparenting aspects of therapy in real-time, even between sessions. Secure Nest is a tool which has the potential to support therapists in providing high intensity treatment.

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Future studies are needed to verify findings. We are currently planning a Randomised Control Trial comparing blended Schema Therapy (e-health) with Group Schema Therapy. We hope to offer workshops in Australia based on the protocols developed for the study.

We have recently improved Secure Nest with the addition of new features following feedback from therapists and clients who have been using Secure Nest, including those who attended the conference. The updates include:

- 'My Journal' – A new space for clients to keep an online journal.
- 'Copy Content' – A button which makes it easy to copy text from the case conceptualisation.
- 'Mode Diary' – Now includes the opportunity for therapists to add feedback to entries and a way to pin past entries at the top of the list.
- Expanded compatible audio file types (which can be uploaded into 'My Files'), improved progress charts in 'Ratings' and additional context provided for platform activities which show in 'Notes.'

We invite anyone who wasn't already familiar with Secure Nest to visit the site, SecureNest.org, where you have the option of signing up for a free trial.

Resent Schema Therapy Articles

de Klerk, Noor, et al. "Schema Therapy for Personality Disorders: a Qualitative Study of Patients' and Therapists' Perspectives." Behavioural and Cognitive Psychotherapy (2016): 1-15.

Fassbinder, E., Schweiger, U., Martius, D., Brand-de Wilde, O., & Arntz, A. (2016). Emotion Regulation in Schema Therapy and Dialectical Behavior Therapy. Frontiers in Psychology, 7, 1373.

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

McIntosh, V. V., Jordan, J., Carter, J. D., Frampton, C. M., McKenzie, J. M., Latner, J. D., & Joyce, P. R. (2016). Psychotherapy for transdiagnostic binge eating: A randomized controlled trial of cognitive-behavioural therapy, appetite-focused cognitive-behavioural therapy, and schema therapy. Psychiatry research, 240, 412-420.

Conference Review

The Rarely Addressed & Richly Entangled Challenge of Treating: Enmeshment and the Undeveloped Self

Kathleen Newdeck (USA)

The workshop, presented by Wendy Behary and Jeff Conway, heightened our awareness of the importance of identifying, understanding and treating the enmeshment/undeveloped self schema, along with accompanying mode patterns. They noted that, in the conceptualization phase, it is important to carefully assess for evidence of enmeshment/undeveloped self as it can be disguised, for example, as the defectiveness, self-sacrifice, subjugation, or abandonment schema.

Dr. Jeffery Young defined the enmeshment/undeveloped self schema as, "Excessive emotional involvement and closeness with one or more significant others (often parents), at the expense of full individuation or normal social development…Often involves the belief that at least one of the enmeshed individuals cannot survive or be happy without the constant support 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." (Young, 2003)

Wendy and Jeff illustrated via video, lecture, and demonstration, how an enmeshed person is typically over-focused on the needs/feelings of others as a source of identity, thus forfeiting their own unique and idiosyncratic sense of self. There are several factors that contribute to the evolution of a patient's enmeshment. It may originate in a family that thrust the child into the role of caregiver or scapegoat. It may also arise from verbal and non-verbal cues that there will be serious consequences (rejection or abandonment, for example) if the individual separates from caregivers, or

caregiver's expectations. As the patient matures, any attempts to become more autonomous are experienced as threatening to family and caregivers who reinforce their disapproval through the interpersonal dynamic of "psychic incest", whereby the family uses obligation, guilt, and fear to maintain the (seeming loyalty) enmeshed relationship. The patient has to forgo the need for autonomy and individuation.

Wendy and Jeff also spoke about the notion of empathic attunement and the necessity for therapists to engage in an understanding of the experiences, feelings and challenges of a patient with an enmeshment schema. Characteristically, these patients have difficulty making and trusting their own decisions, feel controlled by others, are overly involved with the lives of others, and cannot distinguish their emotions from those of their family. It is important to understand the power of "emotional blackmail" (obligation, guilt, and fear) used by the family to keep the patient from pursuing independence and outside connections.

The presenters, in keeping with the conference theme, emphasized the importance of focusing attention on the enmeshment schema/mode pattern of submission to the schema and avoidance of interpersonal connections, and how this pattern "distorts and confuses one's sense of self", ultimately affecting the formation of stable and secure relationships. They described how this might typically show up in the profiles of BPD and NPD patients. As Wendy and Jeff noted, "Healing this pattern positively impacts one's ability to intimately relate to another person".

In summary, the treatment objectives need to focus on pattern identification and using various strategies (Therapy Relationship, Mode Work, and Imagery) targeted at expressing frustration and healthy entitlement about the right to have a "self"; taking graduated risks to "step outside the box"; grieving for anticipated and necessary losses in order to develop a healthy adult mode that can experience a resonant connection with authentic selfness and to fortify satisfying relationships.

Future ISST events

2017 July ISST Summer School- Barcelona Spain

2018 ISST Conference, Washington DC, USA (Date TBA)

Conference Review.....

"Harnessing a Sturdy and Effective Empathically Attuned Caregjver Mode in the Treatment Room." Keynote Address – WENDY BEHARY

Review- Robin Spiro

A self-proclaimed "empathy junkie," Wendy Behary highlighted the differences between "empathy" "sympathy" and "compassion": When experiencing empathy, one feels the other person's experience as they express it and resonates with their emotions, thoughts, attitudes and sensations. Sympathy is a feeling of sorrow for someone's pain and suffering, while compassion is feeling compelled to do something to take away someone's pain and suffering

Wendy provided literary references which brought empathy to life. In To Kill a Mockingbird, Atticus Finch spoke about understanding someone when you "climb into their skin and walk around in them." John Steinbeck said, "you can only understand people if you feel them in yourself." These fictional characters are echoed by psychiatrist/interpersonal-neurobiologist Dan Siegel, who has described the client's experience of "feeling felt." Empathic attunement allows the therapist to "connect the dots" and understand nonverbal and unstated communication.

Wendy suggested nuanced language which helps the patient feel our empathy. Instead of a reflective listening approach in which a therapist may say, "it seems like" or "as I understand it you feel," an empathic response shows a sense of KNOWING as in "must be difficult, given that…", "of course you feel," or "I understand… especially since I know that you…"

Wendy cited neurobiological research showing that in addition to the activation of mirror neurons, empathy is looked at as a kind of "mindreading" of another. It is a predictor of clinical outcome both within psychological and in the medical field. A study at Harvard's Mass General Hospital using the E.M.P.A.T.H.Y. education program resulted in a correlation between improved physician empathy and increased patient satisfaction scores.

Wendy described empathic confrontation as a balance between expressing understanding for the patient's makeup and constructed coping modes (protecting the therapeutic alliance and preventing distractions like defensiveness), while holding the patient responsible for their behavior. With this empathic stance, the patient can be accountable for change without the burden of schema-based shame or unlovability.

Finally, Wendy described a process of "decentering" which can help to bolster therapists when confronted with challenging, critical and angry patients. When therapist's schemas and modes are triggered, we can become preoccupied with attempts to regain a sense of emotional safety or to combat feelings of

incompetenceThe process for decentering ourselves – from the personal affront and schema-driven effects of confrontation – involves taking a moment to connect with our own internal vulnerability and imagine our "little child self" in a safe and appropriate space in our mind, i.e., tucking them into bed, or picturing them in a playful and secure environment where they are not responsible for taking on an angry/bullying patient, or an entitled and demanding narcissist.

Decentering allows therapists to consciously protect their own vulnerable sides, so they can maintain a sturdy and empathic caregiver mode with their patients, and can provide the resonant understanding and realness which is so essential for healing.

Conference Review.....

Identifying and Handling Overcompensation Modes

Robin Spiro (USA)

Odette Brand-de Wilde and Maria Rocher identified overcompensating modes which they encounter in their group therapy with personality disordered patients. The most common modes are Self-Aggrandizer, Bully-and-Attack, Paranoid Overcontroller, Perfectionist Overcontroller, Attention-Seeker, Deceiving Manipulator and Predator. Although overcompensating modes are characterized by disconnection and either hostility or control, they may be experienced as positive because they provide a sense of power.

These modes are very challenging for therapists to respond to, both individually and in a group setting. Based on training by Ida Shaw, Odette and Maria described their pre-therapy work with patients with these modes, where the patient attains a shared conceptualization, agrees to a mode management plan, and to group rules.

Maria and Odette demonstrated the principles of limit setting combined with limited reparenting in a co-facilitated group. A few colleagues were enlisted to play scripted roles in a "group session," augmented by audience volunteers who were able to jump into impromptu roles very convincingly! The group work was inspiring in the sense that participants repeatedly were refocused on the message that their emotions were all valid and important to the leaders, but that their habitual modes could be problematic and needed to be challenged. Empathic confrontation was necessary to create a safe environment for all group members.

This very dynamic workshop provided pearls of learning which can be applied in individual therapy with overcompensators as well as in group settings. The leaders were wonderful role models of tenacity, focus and caring.

Conference- Vienna "Inspire"2016