THE SCHEMA THERAPY BULLETIN

The Official Publication of the International Society of Schema Therapy

Introducing the Inaugural Schema Therapy Bulletin

We are delighted to introduce the Schema Therapy Bulletin, the newest e-publication designed to update members on the latest thoughts, activities and practices related to Schema Therapy.

The exciting world-wide growth of Schema Therapy has expanded the number of schema therapists as well as the populations receiving treatment by schema therapists. Our members, in 26 different countries have advanced the original model developed to treat patients with long-standing personality disorders and chronic mental health conditions to include couples, children, and groups; medically ill patients, people with gender and sexuality issues, dissociative diseases and more. Therapeutic interventions continue to include imagery, flash cards, and limited re-parenting, and have expanded to include mode work using chairs, empathic confrontation, and an expanded view of working with difficult modes.

The Schema Therapy Bulletin will be published quarterly. Each issue will focus on a specific theme: a population, a technique, or a theoretical or practical question related to schema therapist. Future issues will also include a "Meet the ISST Board" column, to introduce our hard-working and highly skilled board to the members at large. Other thoughts have included clinical case-"discussion" focusing on a case relevant to the issues theme, or a question-and-answer forum also focused on the issues theme.
We welcome your input, involvement (and articles!) in this endeavour!
Editors,
Lissa Parsonnet, PhD., LCSW (USA)
Chris Hayes, Clinical Psychologist (Australia)

A message from the ISST President

First of all: Congratulations to Lissa Parsonnet and Chris Hayes getting the Schema Therapy Bulletin started! I am very happy because this means another important landmark enhancing the exchange between our members.

Jeff stated in his lecture in Istanbul on our last conference that the model has to be developed further. Schema therapy is still growing and expanding – in the number of members as well as in terms of a broader application. Starting with successfully treating Borderlines in the last years it has been applied to people with other personality disorders including forensic patients but in other formats as well: In groups, for couples and for children and adolescents. Meanwhile concepts for combining Schema therapy and Axis-I-disorder treatments are on the way too, e.g. for addictions, eating disorders, depression and OCD.

In this May Issue

This progress lasts on two legs: It needs the creativity and sound clinical judgement of experienced clinicians developing the concepts as well as researchers who carefully plan and conduct high quality clinical trials proving their evidence. We all know how much the approval of Schema therapy by the scientific community is based on the studies of Arnoud Arntz and his team of collaborators published in achieved journals! This deserves our greatest respect!

We are starting this first volume with contributions resulting from clinical practice but we will report on outcome studies as soon as they are published keeping you updated with the progress in Schema therapy. So please don´t hesitate submitting the results of your work. Let´s be a creative and vivid community!

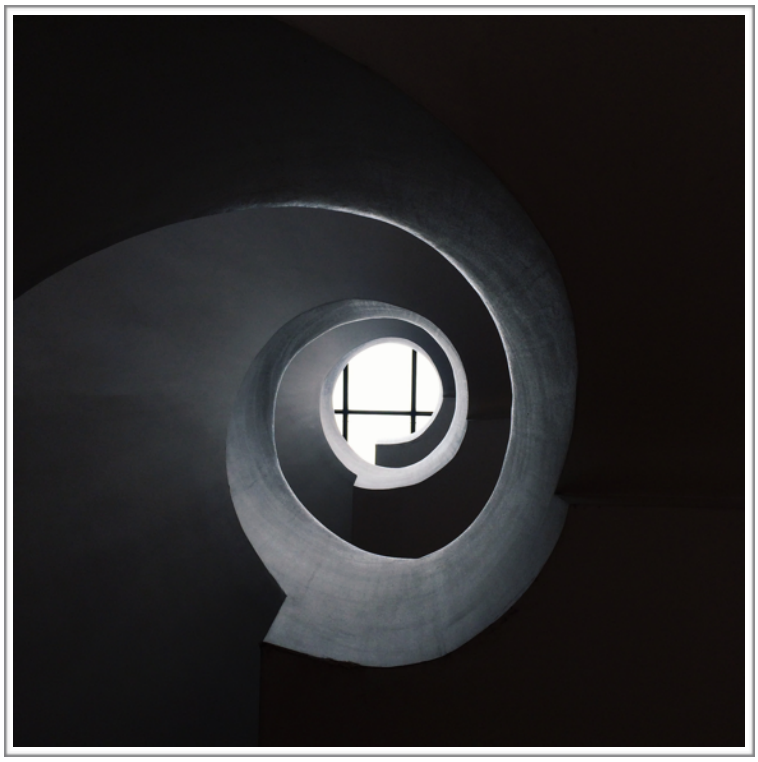
Kind regards,

Eckhard Roediger (ISST President)

Self Pity/Victim: A Surrender Schema Mode

David Edwards
Rhodes University and Schema Therapy Institute of South Africa

One of the psychological games described by Eric Berne (1964) is "Alcoholic" in which the addict draws others into two kinds of relationship with him/or her, as persecutor or rescuer. Stephen Karpman's (1968) "drama triangle" extended this by describing three roles: persecutor, rescuer and victim. He pointed out how troubled individuals may switch from one role to another within the same relationship. In Berne's game, then, the alcoholic is the victim whom others may either persecute or rescue. The point about the drama triangle is that none of these positions is an authentic way of relating. They are all, in the language of schema therapy, coping modes.



In mode terms, it is easy to see that the rescuer is a Compliant Surrenderer. Although the persecutor can be seen as a Bully and Attack mode, it is also an aspect of the Self-Aggrandizer that puts itself above others by being disdainful of them. When this expresses itself in self-righteous scolding, I like to call it a "Scolding Overcontroller" (Edwards, 2012). But what about the victim? Self-pity has been widely described in the literature. In Karen Horney's (1937, pp. 255-6) telling words, such patients present themselves as an "innocent martyr ... a living reproach." Self pity is implicit in several other of Berne's original games (e.g. 'ain't it awful,' 'wooden leg,' 'look how hard I've tried') and in Transactional Analysis it is often subsumed under the broader title of "Poor me" (James, 1977). However, there is a remarkable absence in the schema therapy literature of a mode that captures this position. It is a coping mode in the surrender category, where the patient accepts all the EMS based beliefs, "I'm unlovable, I don't fit in, I'm a failure etc." But this does not open up the Vulnerable Child (VCh) to receive care. Instead, the therapist is pushed away by a barrage of complaints, or a sullen mood that says, "You don't understand," or a string of arguments

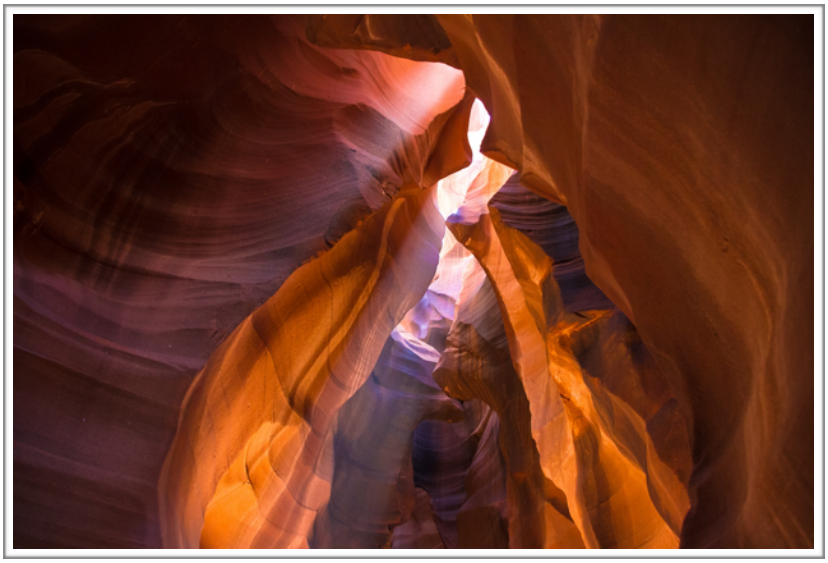
about why change is not possible - Eric Berne described this as the game, "Why don't you .... Yes, but ..." I call it the Self-pity/Victim (SPV) mode (Edwards, 2012).

In his Cognitive Appraisal Therapy, Richard Wessler sees self-pity as a significant obstacle to healing.He developed this after recognizing the limitations of Ellis's REBT, just as Young developed schema therapy to address what he saw as limitations of Beck's cognitive therapy. Wessler, Hankin, and Stern (2001) write about the "help-rejecting complainer" (p. 81), "a litany of complaints about trivia" (p. 139) and a list of "If only"s (e.g. "If only I could have another chance") as typical of this mode (p. 186). Self-pity is also an aspect of narcissistic pathology. O'Brien's (1987) Multiphasic Narcissism Inventory has three factors. The first captures the narcissist's exploitativeness and lack of empathy and reciprocity. The second captures the entitlement to control others (what I call Scolding Overcontroller). O'Brien calls the third the "narcissistically abused personality," (p. 503) while it is referred as the "'poor me' narcissistic defense" by Waller and Campbell (2007, p. 261), in their schema based approach to eating disorders. It is characterized by a sense of martyrdom, striving to avoid criticism, and feeling unwilling to or resentful about being asked to undertake the tasks of therapy.

The therapist is pushed away by a barrage of complaints, or a sullen mood that says, "You don't understand"

Liotti (2004) relates the confusing switches between drama triangle roles (victim, persecutor, rescuer) that characterize patients with disorganized attachment. This means we are particularly likely to encounter the SPV mode in personality disorders and complex trauma. It is, of course, common in addiction, as evidenced by Berne's naming of the game "Alcoholic" (described above) and by the catch phrase from Alcoholics Anonymous, "Poor me, poor me ... pour me a drink." This latter neatly captures the way the SPV mode legitimates a permission giving belief ("it's alright to self-soothe by drinking when I've been treated so unfairly") and undermines access to or strengthening of the Healthy Adult (HA). Because of its strong surrender quality, in some of its guises, the SPV could be mistaken for the VCh. However, Wessler at al (2001, p. 300) warn that trying to offer care to this mode is counterproductive: "caretaking fosters self-pity and anger ... by enhancing their sense of helplessness and distress." It is a defining characteristic of this mode that it does not respond to reparenting. We have to bypass it to get to the VCh. I encountered this in a couple. He felt misunderstood and uncared for despite the fact that for years she had patiently listened to his expressions of distress. She was confused and frustrated. He was apparently vulnerable, but she felt shut out. It was only by unmasking and

empathically confronting his SPV mode that we could break through the impasse. Another patient was confused between the VCh and self-pity in a different way. Whenever she got close to the VCh, she shut down, saying, "I am just going into self-pity." But this was the voice of her Punitive Parent disdaining her genuine feelings (a legacy of narcissistic parenting). It was hard work to undo this and help her accept her VCh feelings and so open up to the possibility of reparenting.



The literature on schema therapy gives remarkably little prominence to the SPV mode. There is nothing like it in the 22 modes listed by Lobbestael, van Vreeswijk, and Arntz (2007). Bernstein andvan den Broeck's (2009) Schema Mode Observer Rating Scale (SMORS) does include a mode that "complains, whines, and demands in a victimized, dissatisfied manner; expresses his dissatisfaction in an off-putting manner that masks his real feelings and needs." This nicely captures the victim, complaining aspects of the SPV mode. They call it the Complaining Protector and comment on some overlap with the Angry Protector mode. However, calling it "Protector" suggests schema avoidance rather than schema surrender. In spite of it being on their rating scale, I could not find any reference to this mode in any of the recent published work from Bernstein's group.

I believe it is important to put the SPV mode more firmly on the schema mode map. Like many other coping modes, SPV is not easy to shift. There are payoffs from the externalization of blame characteristic of SPV: the patient is protected from feeling shame and self-criticism and enjoys a self-righteous satisfaction that has a self-aggrandising quality. But like all coping modes, SPV traps patients in endless cycles of dissatisfaction. It keeps them out of touch with their true needs with the result that they will never be met, and, despite the seeming vulnerability associated with this mode, while in it patients are not able to receive meaningful care, so reparenting is impossible. This mode firmly obstructs the two main pillars of change in schema therapy - the hostile, dependent helplessness prevents building the HA; the self-righteous resentment does not allow access to healing the VCh. So schema therapists need to be

able to recognize it, name it and, in due course, empathically confront it and help patients re-evaluate their investment in such a self-defeating way of coping.

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From Wendy Behary, chair of the Brainstorming Committee:

Jeff Young joins me in acknowledging the efforts of Brainstorming Committee members Lissa Parsonnet and Chris Hayes in the development of this new E-Bulletin, and asked that I express his excitement and support for the launching this new endeavor

Self Pity/ Victim a Listserve Discussion

In May we are encouraging ISST members to discuss the topic of playing a "Victim"/ self pity as a coping mode via the ISST listserve.

The Healthy Adult Mode; Ways to Strengthen the Healthy Adult of Our Patients

Remco van der Wijngaart
The Netherlands

As schema therapists we all strive for the same common goal in treating our patients, to strengthen the healthy adult part of the patient by validating basic core needs. We often explained this therapy goal to patients and for most of them this explanation was clear and sufficient. Some patients however, have questions about this healthy adult part of them. Questions like 'How do I connect to that Healthy side of me?' or 'What does a healthy adult do?'. These questions let us think about ways to make the concept of the Healthy Adult less abstract for our patients. Although some authors describe different aspects of the Healthy Adult (Artnz&Jacob, 2012, Farrell&Shaw, 2012, Van, Jacob, Genderen & Seebauer, 2012) our patients were in need of even more simple guidelines to learn Healthy Adult behaviour. This article describes these methods and techniques and will enable the schema therapist to explain the concept of the Healthy Adult in an easy to understand manner. It also will give a simple step-by-step training of that Healthy Adult.

Visualizing the Healthy Adult

The patient needs to learn to visualize the Healthy Adult to make it a less abstract concept. The way to do that is to start with the therapist explaining about his own Healthy Adult. The therapist self discloses on a memory where he was able to deal with a difficult situation in a healthy way. The therapist mentions all the different aspects of

the Healthy Adult; emotional- cognitive and behavioural aspects. He might say things like: 'That moment I felt confident. And that confidence felt strong; I was holding myself straight, head held high and shoulders straight. And I felt calm, a calm feeling in my belly but at the same time connected, as if I could focus on my feelings but also be aware of the reality that I was facing. And just talking about it now makes me feel that same way. If I had to draw myself being in that mode I would look tall, looking calmly but strong. If I'm now confronted with an upsetting situation, standing up straight with my head held high and my shoulders straight, I do connect to my Healthy Adult, connecting me to that calmness and strength."

The therapist then explains that the patient needs similar gateways to their Healthy Adult as well as a vivid visual image of their Healthy Adult. The therapist asks the patient to close her eyes and get a memory of a situation in which she was connecting to that healthy part. In our experience every patient will have such a memory or more then one; rare moments like deciding to break up a bad relationship. Visualizing the Healthy Adult they were in that situation is a way to identify the different aspects of their Healthy Adult. The homework assignment at the end of that session will be to practise visualizing that Healthy Adult daily in non-challenging situations.

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This is the start of internalising a sense of the Healthy Adult of the patient. Next, we need to explain healthy adult behaviour in looking after the needs of the Vulnerable Child. We explain this using a simple plan called 'the 3 steps of the Healthy Adult'.

The '3-steps of the Healthy Adult'

In our experience, patients really love this simple 3-step plan; it gives them clear instructions and it easy to remember. The first step is to acknowledge the feelings and distress of the Vulnerable Child. A healthy Adult says things like "I see you're upset", "I totally understand that this is painful", "If I was in that situation I would feel bad myself". So the patient has to learn to say things like "I'm upset and that's understandable, I never learned to feel safe in these situations. It's my Vulnerable Child that has been triggered". This acknowledgement of the suffering is a soothing way of connecting.

The second step is to offer hope, a different perspective. Acknowledgment is a necessary first step but if it would just be acknowledgment then it wouldn't be enough. Words like "This will go away, that's a fact", "It will change" give a clear and healthy message that distress can be overwhelming but that it will not stay that way, how strong that overwhelming feeling may be. It's important that the patient learns remind themselves of this message and make it more then just hollow words.

The third and final step of the Healthy Adult is to deal with reality. Dealing with reality may mean different things. It often relates to deal with parent modes or coping modes that were triggered and were part of the reason why the patient was in so much pain. Dealing with reality also means making healthy behavioural choices how to solve a problem or cope with a difficult situation.

The three steps have to be taken in this specific order. One common pitfall is that a person immediately tries to solve things when faced with an upsetting situation, to take action. Although action is a necessary step it's only effective if it is first acknowledged how much the other is in pain. In some way we're all aware of that necessary first step. Just imagine that you feel bad because of what happened at work, return to your home and talk about these difficulties with your loved ones. When these loved ones immediately start to give advice how to deal with that situation ("What you should do is…", "What I would do is…") that might feel irritating. Although these solutions may be very wise, it's too soon. First we need to hear that our pain is acknowledged, understood, before we can be open to suggestions how to take action.

Depending on the pathology of the patient we tend to start to visualize the Healthy Adult during the middle phase of the therapy. Next, that Healthy Adult of the patient is present in imagery exercises while the therapist does the rescripting. Then we start to explain about the 3 steps so the patient will cognitively understand what she needs to

learn to do for herself. The therapist may still do the rescripting but will also explicitly point out these 3 steps to the patient. In the last phase of therapy the patient is coached to practise the Healthy Adult herself. The therapist will ask questions like "Did you do the 3 steps?' and thereby coaching the patient to strengthen her Healthy Adult.

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Special thanks to my collegues of the day time clinic in Maastricht, specifically Judith van Hommerig who was the first to mention the 3 steps of the Healthy Adult.

"White Nights" Summer School June 2015 St Petersburg Russia

Do you want to enhance your skills and expertise as a schema therapist?

ISST invites you to join us for Summer School June 11, 12, 13 2015. We will be hosting top experts in the field of schema therapy to present at workshops designed to help you broaden and expand your work with select populations and areas. To for more information see www.schematherapysociety.org

ISST New Website

2015 brings us a new and improved ISST website. www.schematherapysociety.org The new look website now has new features such as an improved blog area, an international events calendar, "find a Therapist/ Supervisor" facilities.

In the coming months the website will continue to expand with video features and schema resources for members.

Face to Face With "Anger Modes" Sturdy and Secure In The Treatment Room

Wendy T. Behary
The Cognitive Therapy Center of NJ
The NJ-NYC Institutes for Schema Therapy

Whether it's the ornery cynicism launched by the obnoxious narcissist, defiantly refusing to engage in your *"silly emotional strategies"*…. Or the patient who flips into a desperate angry child mode, hurling guilt-activating blame at you for daring to call it 'vacation time' when *she knows* you are really *'looking forward to getting away from the hopelessly pathetic and forgettable person that she is, and that you are just like everyone else in her life who doesn't care'* … Or perhaps it is the *partner* in your couple's treatment who offends his significant other (and you) with contemptuous

rants of *"I'll show you"* and *"I don't need you"* bullying statements and gestures… Or it might even be the patient who nods and *"yes's"* your every word in a somewhat mechanical mode of compliance, and then proceeds to arrive 20 minutes late to each session that ends with an agreement to engage in emotional work *"next time we meet"*… and when you inquire about any hidden anger, frustration, or resentment toward you (perhaps linked to feelings of subjugation, shame, or mistrust) for confronting blocking modes, they become punitively self-critical for being such a *"loser and a waste of your time"*.

We struggle to keep a sturdy posture when ANGER enters our treatment rooms. Whether the anger is directed at us, at an attending partner, or through an unabashed reenactment of a recent event: *"… and then I got really mad when… and then I showed him! I just let him have it!!"* we may find ourselves overwhelmed dazed with fear, glazed in apologies, hazed with resentment, or simply amazed by the speed with which the deep red hue of humiliation arrives on our faces.

We hear the anger as a siren, a blaring emergency vehicle that alerts us to the message that "someone is in trouble" or simply "help is needed"!

However, when responding from our healthy adult mode… we become harnessed in an awareness of the "importance" of anger modes and the underlying experience. We hear the anger as a siren, a blaring emergency vehicle that alerts us to the message that "someone is in trouble" or simply "help is needed"! From a sturdy mode we hear the *siren* and empathically listen for cues to distinguish between an angry childlike helpless mode, a rebellious teen-like bully, or a demandingly entitled, resentful, or defiantly detached adult. Only from this mode can we discover and be reminded of the patient's unmet needs for: safety, limit setting, empathy, acceptance, and/or attachment. We appreciate the internalized experience imbedded in a story of fractured attachment and communicate to our patients how a seemingly "important" message seems to have *gotten lost in the delivery.* From the healthy adult mode we are better equipped to confront or embrace *angry modes* with the effective and targeted strategies founded in the Schema Therapy approach… be it imagery, mode dialogues, limit-setting, or empathic confrontation.

It is essential to label the Anger Mode with a personally customized descriptor, in order to fully capture the motivating driver behind the mode one of helplessness, resentment, fear, or rejection linking it to early experience, EMS, coping styles, and

hypothesized temperament. The personal label may also be helpful for linking the physical experience, as identified by the sensory system, i.e., locating the feeling in the body at onset and during escalations. The personal mode descriptor may also serve to remind us, as well as our patients, to mindfully anticipate (and review in the aftermath) the precipitating condition(s): those most likely to activate the anger mode, such as: being teased, ignored, controlled, or betrayed. Customized anger mode labels may be designed like this: "Bully Joe", "Pressure-Cooker Peter", "Seething Sue", "Little Angry Laura", or simply "Tough-Guy"… "Stormy"… or "Cranky Pants".

Given the nature of our species and the architecture of the primitive brain, most humans are likely to experience some degree of anger, agitation, frustration, and aggression whether in the *natural* early years of development when frustration and discomfort is expressed in the form of wailing cries, moaning monologues of sounds and words, or even physical aggression. Differentiated in the treatment room, schema-driven anger is identified as marked intensity of reaction to stimuli (not necessarily loud or violent) typically linked to an overestimation of a "threat" to their emotional survival, linked to the patient's longstanding unmet needs and self-defeating reactive patterns of *defiant detachment, controlling-demands, attacking-criticalness, internalized punitiveness*, or desperate efforts to satisfy the need to aggress frustrations safely, as we find with BPD patients in the *angry child* mode.

Anger can cause great distraction for therapists, causing us to flip into our own maladaptive modes in order to protect us from *sensed threats* and schema-activated discomfort. These modes thwart the sturdiness and *realness* that is necessary for the healthy adult caregiving role. When triggered, receptivity and accessibility for attunement and attachment healing is impacted, thus compromising our ability to help patients navigate the challenging freedom journey from prevailing maladaptive modes.

Schema Special Interest Groups- get involved!

There are a number of Schema Therapy Special interest groups that meet regularly to discuss specific aspects of schema therapy. These include

- couples work
- forensic work
- eating disorders
- child and adolescent

To be a part of these group visit the ISST website.

Research Blog

For recent developments in Schema Therapy research see the new ISST research blog- www.schematherapysociety.org/Research-Blog

Being stuck in our *"lost adult"* and maladaptive-reactive modes also impedes our capacity to model and co-construct adaptive, flexible, coping stances necessary for engaging patients in getting their needs met in a healthy way.

Keeping a few (child and adolescent) photographs of your patient in the chart can act as healthy adult fortifiers for us, helpful reminders in session (as you look into the faces in the photos) and recall the stories of these suffering and vulnerable parts that lie beneath (noisy, obnoxious, cynical, raging) angry over-compensators, defiantly detached protectors, bully, controlling, and demanding modes; and to also remind us of the anger that lies trapped within the child who was not only deprived, abused, or abandoned, but also suffered the absence of the natural relief that comes from the freedom to *naturally* express frustration without harming or neglectful consequences… anger that is met with embrace, empathy, and healthy constructive discipline.

The ongoing maintenance of our wellbeing as caregivers is imperative to the effective discernment and engagement with this important emotion when it shows up in our treatment rooms. Self-therapy, supervision, and personal therapy are a few of the ways we can remain steadier (not robotic) and also informed by our *humanness* (our own vulnerability) and thereby appreciative of the impact the patient's anger may be having on others in deleterious ways.

Sturdy and secure in our Healthy Adult caregiver modes, and with a keen conceptualization of schemas, modes, and unmet needs of our patients, we are better able to extract the meaningful messages imbedded in the anger that is being used to block emotions… maintain rank/status… protect against shame/loss/abuse… aggress punishment in the name of injustice, control, or impulse… or simply release frustration in a safe place.

Coming Soon – Paper in Press:
Beyond the Angry Child: A New Conceptualization of Anger Modes and Their Treatment
Dr. John Gasiewski and Wendy Behary

New Directions for Working with Dysfunctional Parent Modes

Offer Maurer and Eshkol Rafaeli
The Israeli Institute for Schema Therapy

It is a well-known fact that some individuals are their own worst enemies. This phenomenon has been recognized by many approaches which described the dynamic using various terms. Common to all these approaches is the recognition that through identification and introjection, children learn to treat themselves in just the same ways their parents treated them ways that are at times quite dysfunctional. Although the terms introduced by Young to label hurtful internalized self-states in the Schema Therapy (ST) model point directly to the parents as their source (e.g., the Punitive Parent or the Demanding Parent Modes), neither we nor Young himself take it to imply that all critical, punitive, or demanding modes must always be the result of direct internalization of parental figures (Young, Klosko & Weishaar, 2003). At times, these modes echo the words and actions of other influential sources like siblings, peer groups or even broader society's messages.

One of the most important goals in ST is to help the client identify these modes, view them as ego-alien voices, assertively stand up to them, and learn to protect and shield the Vulnerable Child mode from their destructive effects. Various tools can be employed in ST for this purpose, yet ST's most powerful tools for combatting the Dysfunctional Parental Modes (DPM) are experiential strategies, particularly chairwork (Kellogg, 2004) and Imagery Rescripting (ImRS; Arntz & Jacob, 2012, Rafaeli, Bernstein & Young, 2011).

When therapists request permission and enter an image, they typically do so with four broad goals in mind. They want to (1) bypass the various **coping modes** which often block feeling. They aim to (2) nurture or re-parent the **child modes**, especially

the Vulnerable Child. By doing so, they hope to (3) model adaptive parenting so that the patient's own **healthy adult mode** is strengthened. Often times, this involves (4) confronting or combating the internalized **parent or perpetrator modes**.

Of these goals, we find the first three incontrovertible. This is not the case, however, with regards to the fourth goal the one tied to addressing parent or perpetrator modes. In recent years, we have begun to doubt whether directly and forcefully "taking on" the internal hurtful self-states of our patients is the only clinical avenue possible. We have no doubt that this avenue should exist, nor that there is convincing evidence for its utility (e.g., Arntz, Klokman & Sieswerda, 2005; cf., Bamelis, Giesen-Bloo, Bernstein, & Arntz, 2012). Still, our own clinical impressions, those of our supervisees, and those of therapists from various (quite compatible) schools of therapy point to other clinical options, ones which might hold promising merits (Rafaeli, Maurer & Thoma, 2014).

We have begun to doubt whether directly and forcefully "taking on" the internal hurtful self-states of our patients is the only clinical avenue

To illustrate our thinking about this issue, we would like to share an instructive experience one of us (OM) had while studying with Dr. Suzette Boon, an internationally renowned trauma expert who's best known for her work with patients suffering from Dissociative Identity Disorder (DID). After watching some video clips from real patients' sessions she presented at a workshop, I was struck by the tremendous amount of respect (and even what I felt to be genuine gentleness!) she showed towards pretty horrific malevolent self-states within her dissociative patients. This, of course, stood in stark opposition to the ST model's approach. Curious, I came up to her during the break and asked her about this discrepancy. Dr. Boon told me about her own experience with ST, during which she had attempted to confront malicious self-states in the manner prescribed by the model. The results, she said, were at times problematic. In particular, though patients seemed to be experiencing some relief in session, the internal attackers came back to haunt and punish the patients later at home with even more vengeance then before. Some patients, she said, would then need even more care and protection due to an increase in their suicidality. These experiences and others led her, she said, to change the way she worked with critical or punitive self-states to a one that's more respectful and gentle to them (S. Boon, personal communication, May 18, 2011).

This and other clinical observations have served as an important starting point for us in our search to expand our own (and our supervisees') toolbox for engaging and working with DPMs. Today, when we encounter these modes, we often view them as internal representations of parents (and others) who just did not - and maybe *still* do not - know how to treat their children right, mainly because of their own deficient upbringing. After realising we're not against them, these modes often come out, with some tentativeness, and seek counsel with us. Many of them agree to change their ways after getting enough reassurance and guidance (Maurer, 2015).

One way to think about this style of work is by analogy to the therapeutic stance adopted when working with real parents in parental-guidance sessions. In many instances, parents enter hoping to be discuss their child's symptoms, only to discover that the clinician conceptualizes things quite differently; in particular, it often becomes evident (at least to the clinician) that the underlying cause of the presenting problems resides with the unmet (or inadequately met) needs of the child. With forthcoming families, a discussion focused on the child's needs and the parents' responses to it often leads to a recognition of the parents' schemas and modes and to their developmental origins; such recognition later leads to personal growth and change both in the parents and in the child.

Sensible therapists typically wouldn't begin parent training interventions with forceful confrontation, but instead would try to empathize or understand the parents, even as they attempt to correct problematic behaviours. We propose that the same principle applies to work with a DPM. As we've seen repeatedly, most parents who were overly demanding, strongly critical or mercilessly punitive were so not because of a wish to hurt their child (although sadly this might indeed be the case in the minority of cases) but because they themselves were activated into a Maladaptive Coping Mode or a DPM of their own, making it impossible for them to respond to their child's needs in a good enough manner.

Recent Schema Book/ Chapter releases

Breaking Negative Thinking Patterns (2015) Gitta Jacob, Hannie van Genderen, and Laura Seebauer

"Schema Therapy with Oncology Patients and Families" (2015) Dr. Lissa Parsonnet, in Handbook of Oncology Social Work: Psychosocial Care for People with Cancer,

Narcissistic Personality Disorder Wendy Behary & Denise Davis. Cognitive Therapy for Personality Disorders (2014, 3rd ed).

Borderline Personality Disorder Arnoud Arntz . Cognitive Therapy for Personality Disorders (2014, 3rd ed.)

A related point has to do with the notion that treating the violence of the DPM with violence could prove to be quite problematic in the long run. When we strive to to 'banish' the parental modes, or when we treat them harshly, we may be just repaying them with the same old coin. Although the Vulnerable Child Mode may actually value this (and at times really need this, especially when it's done to save or protect her/him from severe maltreatment) he/she is actually missing out an important chance to learn new ways of interacting and negotiating, ways marked by compassion and empathy.

To conclude, we'd like to reiterate that these new directions involving a softer response to the DPMs are proposed here not as replacement of the established ST way, but rather as a variant to it. Developing this variant could expand the diversity of tools available to present-day schema therapists. Over time, we hope to elaborate on the specifics of this line of intervention: when should it be used in the course of therapy, how should it be combined with the more classic approach, and how should one determine which is superior in any particular juncture in therapy.

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Announcement- 2016 International Society of Schema Therapy ConferenceVienna, Austria

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

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

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

Schema Therapy Bulletin- Upcoming Editions

The Bulletin is dependent on member involvement. We are looking for contributors for upcoming editions of the Schema Therapy Bulletin. In the coming 18 months we hope to have to have material focusing on-

-Schema Therapy and Medical Conditions (Release date- September 2015) ,

- Schema Therapy and Couples Therapy

- Trauma and Schema Therapy

If you are willing to contribute an article to your society, please email Lissa Parsonnet drlissap@gmail.com or Chris Hayes chrishayesperth@gmail.com. We look forward to hearing from you!