THE SCHEMA THERAPY BULLETIN

The Official Publication of the International Society of Schema Therapy

This issue- Case Studies in Schema Therapy

Issue 8 of the Schema Therapy Bulletin offers three case presentations using Schema Therapy.

In the first article "The Hedgehog and the Prickles", Galit Goren Gilead presents her very creative work in helping a 12 year old boy who refused to go to school to work with his Avoidant Coping Mode. Using play therapy techniques, without the interpretive efforts in traditional psychodynamic therapy , the author was able to bypass and then weaken the avoidant coping mode, identify and strengthen the happy child mode, and begin to develop a healthy adult mode.

Christof Loose shared the case of Schema Therapeutic Outpatient Treatment of a 15 year old boy with Hypochondria Against the Background of a Car Accident Caused Paraplegia Early in Childhood. In this case, the adolescent boy was referred for fear of dying, fatigue, depression and avoidance, along with physiological symptoms which interfered with school attendance as well as with other age-appropriate functioning. The author describes the five step schema therapy intervention that impact the teens symptoms and functioning.

The final case discussion: "Mad for Connection", is a "Case Study in Schema Therapy for Anorexia Noervosa" by Suzy Redston, in which schema mode work provided an understanding of the patients behaviors. Working to contain the angry child, the angry protector and the demanding child helped to find and soothe the vulnerable child, enabling the patient to work

In this November Issue

toward his goal of being able to have a healthy intimate relationship.

In our ongoing "Meet the Board" series, Vivian Francesco interviewed Travis Atkinson, who ably manages Public Affairs for the ISST.

We are currently seeking articles for future issues of the Schema Therapy Bulletin, and would be particularly interested in hearing from people doing Schema Therapy with underserved or marginalised

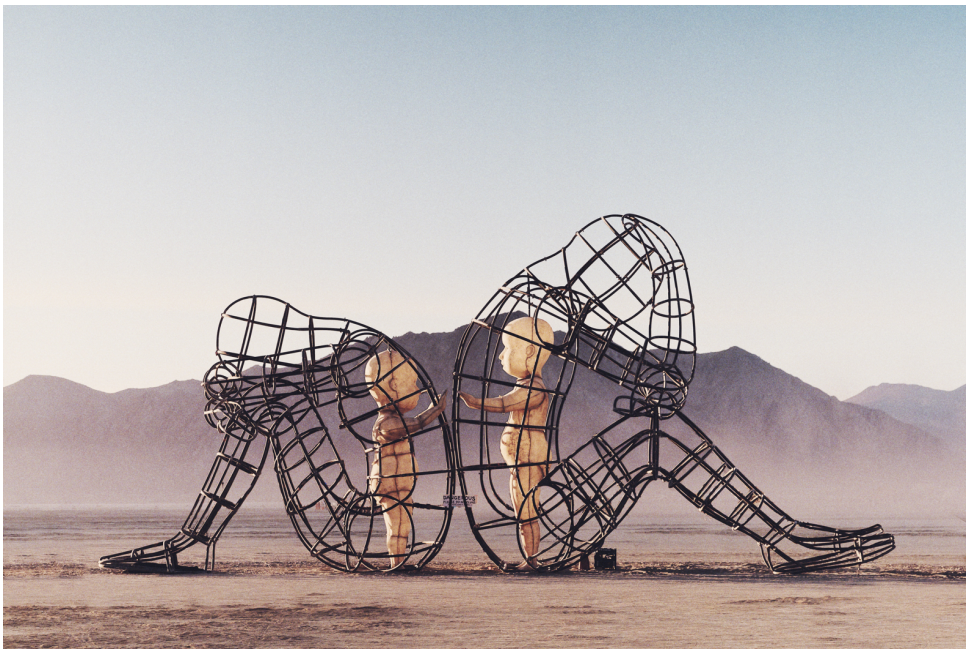
Lissa Parsonnet, PhD, LCSW (USA) & Chris Hayes Clinical Psychologist (Australia)

The Hedgehog and the Prickles – A Case Study of Dealing with Avoidant Coping Mode

Galit Goren Gilad (Israel)
Clinical Psychologist
Private Practice

Y was 12 years old when he was referred to me by his psychiatrist. "He refuses to go into the classroom for 2 weeks now," his mother told me on the phone in a low, sad voice. "We practically have to push him in, with the teacher's help, and it's not easy, he's a big boy already. And when he does get in finally, we have to go through the whole circus again the next hour."

It turned out that Y was an only child. He was a good and quiet boy, who played computer games after school, never went outdoors or met with friends – "but this is how children are



nowadays, right?" He rarely did anything fun with his parents, since it seemed everyone was most satisfied with staying home. "Everything was just fine," said his mother, lost and confused, "but now he says he wants to kill himself."

My heart sunk. Difficult age, and difficult symptoms. I hoped the SSRIs would help.

Y proved to be bright, talkative and even slightly lively as long as I did not direct the conversation to the steps necessary for his improvement. Whenever he felt pushed to action, or even to a discussion about improving, he would look at the floor and stubbornly shrug in silence at every question, thought or suggestion I made. This avoidant mode was a constant dead end.

Like his parents, Y could tell no clear story about the trigger or the process that started all this. But he was determined not go to back to school. "I'd much rather stay home with my computer. Besides," he added with no sign of humor, "this gets me lots of attention and I sure need *that*."

“We then told the story of the little, soft hedgehog, who was afraid of the world since no one ever took him by the hand and showed him around”

Still, he readily walked the path with me when I tried to conceptualize his modes. We then told the story of the little, soft hedgehog, who was afraid of the world since no one ever took him by the hand and showed him around. To protect himself, the fearful hedgehog covered himself with prickles and rolled himself to a small ball. That felt safe. Lately, he realized Prickles also gets him the attention and availability of his parents. That sure felt safe. And nice.

"Y refused to cooperate with any CBT exposures – not even imaginal ones. He once smartly pointed out, "if I do *that*, you'll then expect me to do the real thing"

This gave us a kind of private vocabulary, to describe the vulnerable child and the avoidant coping mode, but I still had no idea how to get Y out of his prickles mode, that often got us stuck in sessions.

Still, the medication was helping, as well as the efforts his parents and the school put in. He was given a special assistant, a woman whose job was to help him get into class and stay there – for he sometimes left class in the middle of a lesson, overwhelmed by something that had happened (such as the teacher announcing an exam was coming up later in the week), and wasn't able to get back in.

Y refused to cooperate with any CBT exposures – not even imaginal ones. He once smartly pointed out, "if I do *that*, you'll then expect me to do the real thing". But usually there could not even be a *discussion*. He would go into Prickles and cease talking.

In one such session, desperate to get him out of Prickles, I wrote on a piece of paper – "Hey. I know you are there. I know you want me to reach you". I then rolled it to a ball and threw at him. Instinctively, he caught the paper ball. He was too curious not to read it. Encouraged, I went on. "It's not easy but I'll keep on trying". Throw. Catch. "I won't give up on you. Because I remember the little hedgehog inside needs someone to be with him." Throw. Catch. I could see that the **physical motion** did some change. It began to melt the avoidance. I could see he is waiting for my next ball of paper, and that his eyes are filling up. "I know he can hear me. I know he can see me." Throw. Catch. The transformation of modes in front of my eyes reminded me of my children, who would sometimes bury each other in sand on the beach, only to suddenly rise up laughing, shaking off the sand – "Here I am, Mummy! Did you see me?"

I brought a real soft, small ball to our next session, and also a bunch of playing cards. These proved to be very helpful. Playing consistently pulled Y out of Prickles. This opened the way to discuss his daily life avoidance in much more depth, since the conversation was not in danger to get stuck anymore. I never used the games to give interpretations, like in classical dynamic play-therapy, since I didn't want to elicit self-consciousness in Y during the game. So **playfulness** was one key to defeat avoidance (with older avoidant patients, playfulness was achieved through enthusiastic discussions about their special area of interest, such as physics or movies).

I tried to lean again on attachment statements, like I did with the paper ball, but that worked only now and then. Maybe I wasn't always as genuine as in the first episode. It was only much later that we found that another antidote for Prickles was **emotions** – any kind of them. It didn't have to be joy – like in the case of games, or sadness like in the case of my paper balls. I

recall once, Y came in prickled, but was slowly able to tell me that his mother didn't emotionally support him after failing a test (which was not like her). Being able to feel his anger, pulled him out of Prickles.

Another element that helped in this paper ball episode, was the feeling that some **significant other was available**. That helped a lot later in therapy, when Y faced advanced challenges such as going on a field trip with his class, or inviting friends over. The nature of the availability would change in the course of therapy, from very concrete and immediate to a more subtle one.

Curiosity was also a helpful element. In the paper ball episode, Y was curious to read what I'd written. In a way, curiosity is the opposite of avoidance, since it promotes going towards, rather than going away. I used it later in therapy through introducing new games, as well as encouraging his parents to initiate activities that he would perceive as new and compelling.

After reading the case study, Y asked to add another component which helped in his view to melt down the avoidance: a sense of **belonging**, feeling a part of something bigger than himself.

Methods of Weakening an Avoidant Coping Mode:

- Encourage Physical motion (even as minimal as shuffling cards)
- Evoke Playfulness – strengthen the happy child mode
- Elicit Curiosity – strengthen the happy child mode
- Uncover emotions – reach out for the happy, vulnerable and angry child modes
- Make the availability of a significant other possible or clear
- Engage in activities and create a therapeutic relationship that evoke a sense of belonging

Y's parents made great efforts to find activities that would take him out of his comfort zone. He volunteered in an animal's farm, and joined a summer camp of young scientists. They went on several hikes, and got a dog, who made it necessary for Y to get out of the house daily. But although Y seemed to enjoy all these activities, he heavily relied on his parents to force him to do them, just as in school he relied on the assistant to get him into his classes, and just like in the sessions it was always me who initiated playing when Prickles came to town. He still took no responsibility over his mode shifts.

But the positive exposure to the outside world did have an effect. Y got attention from his parents not through Prickles alone, and also came to like some of these activities and was disappointed when Prickles got in his way of engaging in them. He was now willing to describe Prickles as a "kidnapper", and discuss ways to "escape captivity". We came to know "Mature Y", who can command the actions needed to free the Hedgehog and himself from "prison".

ISST News

Recent Schema Research

Tapia, G., Perez-Dandieu, B., Lenoir, H., Othily, E., Gray, M., & Delile, J. M. (2017). Treating addiction with schema therapy and EMDR in women with co-occurring SUD and PTSD: A pilot study. *Journal of Substance Use*, 1-7.

Renner, F., DeRubeis, R., Arntz, A., Peeters, F., Lobbestael, J., & Huibers, M. (2017). Exploring mechanisms of change in schema therapy for chronic depression. *Journal of Behavior Therapy and Experimental Psychiatry*.

Van Wijk-Herbrink, M. F., Broers, N. J., Roelofs, J., & Bernstein, D. P. (2017). Schema therapy in adolescents with disruptive behavior disorders. *International Journal of Forensic Mental Health*, 1-19.

McIntosh, C. (2017). Schema Therapy for Problem Gamblers. In *Evidence-Based Treatments for Problem Gambling* (pp. 51-62). Springer, Cham.

Still concerned about his lack of responsibility and initiative, I asked him in the beginning of the school year to set goals for this year. Y said he would like to be able to visit friends from school and have them come over, since having activities with his parents at his age is usually "boring" or plain "weird". He was also willing to reduce his reliance on the school assistant. I wrote that on a piece of paper. Later on in therapy, Y denied this will many times when he was "prickled", but I was able to wave my piece of paper, claiming this was the will of Mature Y, and only when he is present we can discuss changes in it. This was the beginning of a long, ongoing way, for Y to take over his process.

Today, Y is seeing friends regularly, and does not need the help of the school assistant anymore. He participates in extra-curriculum activities, and goes to gym frequently. He still struggles with Prickles. It was only recently that his friends knocked on his door, causing him such a wave of panic, he hid silently in the house, hugging his dog. But after they were gone, he was able to call his father and ask for his help to join them.

The work I've done so far with Y consisted mainly of weakening the avoidant coping mode, and strengthening the happy child and the adult mode. Now more work is needed – especially for the weakening of the critical parent mode, and weakening the compliant coping mode, thus strengthening his assertiveness. This lineup is not meant to be a protocol, and may or may not be applicable for other avoidant patients. My main aim was to demonstrate different ways for weakening the avoidant coping mode, which oftentimes obstructs the therapeutic work.

Meet the Board- Travis Atkinson

with Vivian Francesco

What role do you play on the ISST Executive Board and what made you want to run for that role?

When I was pursuing my clinical training in graduate school, I did a joint program in not-for-profit management at New York University, with a focus on marketing. As I built up my therapeutic practice and center, I also stayed involved in not-for-profit organizations. I helped Jeff Young initially establish the Schema Therapy Training Institute and served on the Executive Board for the New York Center for Emotionally Focused Therapy. In 2014. When George Lockwood announced he was going to retire from his position on ISST's Executive Board as Public Relations Coordinator after serving diligently for 4 years, I thought it would be an ideal time to get involved in an area I am passionate about, and one where I could take advantage of the technological skills and tools I have learned in order to focus on promoting Schema Therapy.

In 2014, ISST was in a major transitional period in terms of media. Technical issues had hampered prior efforts to update our platforms, and I was determined to overhaul our media offerings. Since I enjoy learning new technologies, serving in this role seemed like an ideal fit. With the help of former ISST President Eckhard Roediger, and other Board Members, we have modernized our website, listserv, social media, and even introduced a Schema Therapy Events app that we successfully used at INSPIRE 2016 in Vienna, and Barcelona Summer School.

How did you first learn about Schema Therapy and where did you get your training?

When Reinventing Your Life was first published in 1993, it was a featured book of the then Quality Paperback Book Club (remember those?), and I was about to complete my undergraduate studies at Brigham Young University in Provo, Utah. It was the first psychotherapy book at that time that made complete sense to me, with refreshingly clear strategies for change.

Since I was moving to New York to attend graduate school, I made it a goal to meet Jeff Young, which I did in 1995 when I enrolled in his training program. I started supervision with Will Swift, who helped Jeff develop the schema therapy model, and completed all the courses in Jeff's program. In 1998, I was fortunate enough to be hired by Jeff as a staff psychotherapist at his center, the Cognitive Therapy Center of New York.

Some of my fondest memories are working together with other wonderful staff members along with Jeff at monthly "case conferences," where I met so many other incredible staff members, including Wendy Behary, Cathy Flanagan, Scott Kellogg, the late Catherine Amon, Daniel Mattila, Jayne Rygh, Fred Eberstadt, Molly Schroeder, Janet Klosko, Michael Minervini, Michael First, Marsha Blank, Pat McDonald, Scott Shapiro, Patricia Escudero Rotman, David Bricker, the late Lillian Steinmuller and her husband Robert, and last bit not least, you, Vivian, along with so many more. We were a team and a community sharing the same passion for schema therapy! I miss the days when we were discussing the ins and outs of so many aspects of clinical work under the leadership of Jeff!

How did you first get involved with Schema Therapy?

Schema Therapy has always been my primary therapeutic orientation and I have worked to specialize in using Schema Therapy with couples since 1998, first attending and completing several years of training with the Gottman Institute in Seattle, Washington, and then under the supervision of Sue Johnson in Ottawa as well as Emotionally Focused Therapy. I also completed two institute training programs in group psychotherapy, and have always made it a focus to learn more.

How do you see Schema Therapy evolving?

I see Schema Therapy evolving to broaden the perspective of other psychotherapies, wherein we embrace similarities that work well together while maintaining the integrity of the model. Schema Therapy offers the world a specific framework that is one of the main reasons for the successful outcome studies through the years, guiding therapists to shift unhealthy modes to more adaptive and flexible states. Our worldwide community of therapists has and will continue to expand and fine-tune techniques for even better outcomes. Our membership has more than doubled since 2014 and we anticipate that this rapid growth will continue given continued advances in technology. It's incredible how members from even remote places can feel like they are in the same room!

How do you get into your Happy Child Mode?

In my "happy child" mode, I am an adventurer and I treasure my time with my husband Ian exploring around our weekend home in Vermont with activities like skiing, hiking, kayaking, and running. That last one is something I never thought I would say, as I used to abhor running, probably stemming from a "punitive" cross country coach in high school! Over the last couple of years, it has felt great to compete. I can't wait for more adventures...

Are there any other thoughts or ideas that you would like to share with our ISST family?

One of the greatest benefits of being a member of ISST is that it embraces our similarities, and celebrates our differences. The ISST Executive Board will be coming out with a Diversity Statement very shortly to codify our commitment to and value of all members of our international society. We

welcome all, regardless of what they look like, where they come from, how they worship, or who they love. Especially in our times, I am proud to serve and be part of an organization with a mission to unite, when so many forces around us pull to divide.

Schema therapeutic outpatient treatment of a 15-year-old boy with hypochondria against the background of a car accident caused paraplegia early in childhood

Dr Christof Loose
Child and Adolescent Psychotherapist
Heinrich-Heine-University Dusseldorf
Institute of Experimental Psychology dept. Clinical Psychology

The reasons for the referral were vast: fear of dying, fatigue, and depression symptoms such as inactivity as well as social and emotional retreat; the teenager could not think about anything else other than his (to him unknown or awkward) physiological experiences such as dizziness or an extra systole could be the first signs of life-threatening diseases (e.g. brain tumor or heart disease). Numerous medical examinations, sometimes in emergency medical consultation, revealed no medical diagnosis. Since these problems did not only occur only at home, but also at school, significant social integration and achievement problems also arose. For example, about once or twice daily the patient had to leave the classroom, complaining about symptoms, and demanding immediate access to a rest room, where a personal school assist would help him to rest until the symptoms faded. After usually about 20-30 min, he returned to the classroom, to be met with the dismissing looks from peers and also at times from teachers.

Treatment Phase 1: Resources, Strengths, & Positive Schemas

In weekly outpatient psychotherapy sessions, we first started to build up a viable relationship by exploring resources, strengths, and positive schemas. The idea of working with positive schemas is not new in Schema Therapy (ST, e.g. Early Adaptive Schemas by Lockwood & Shaw, 2012; *Lockwood* & Perris; 2012), but in ST with Children and Adolescents (ST-CA) we systematically use it in order to bring into awareness and reinforce the patient's positive experiences, and connect them (internally) with significant others in their lives. For that reason, we interpret the absence of an early maladaptive schema in a pragmatic way as a presence of the corresponding positive schema (e.g. trust if mistrust is absent; stability, if no instability schema is prevalent; and so on). Peter Graaf and I gathered from a heuristic point of view typical expressions of positive schemas from 10 years upwards. However, in order to determine the patient's most common expression of the 18 positive schemas, we invite the patient to "travel back" in his life history and imagine a socio-emotional key moment in which he/she has had an experience that helped him/her to build up this particular positive schema. For example, the expression "I am me, and an individual person", represents the positive schema of *individuality* (opposite to the e*nmeshment* schema). In an imagery exercise, we went back to the situation and the particular person who helped to build up this very particular attitude to himself. With other words, we got in touch with the helping person

(need for attachment to good people), expressed our gratitude (emotional touching moment helped to use a positive affective bridge) and connected this experience from the past with a transitional object, i.e. semiprecious stone out of a box of different symbols. Finally, we put the symbol (here: stone) in a treasure bag of hand size, that the patient took home in his pocket. Having done so, we would fill the treasure bag week per week with a new stone or another small symbol, facilitating a new positive recollection, and thus connecting with another good person and moment. Systematically, we build up a positive self-image, creating a deep, satisfying feeling of being connected to good people in his life (Patient: *„My life was much better than I thought"*), and the awareness how good it is to have people around who take care of them.

This model gave the patient a plausible, self-supporting, and individually tailored explanation why even harmless dizziness or other physiological sensations may have led to such deep fears

Treatment Phase 2: Psychoeducational Model

With the aid of a mode sketch (Fig. 1) we could shed some light into the so-called "black box" from a mode's perspective: What exactly happens on the inner stage (mode level), when a stimulus (S, here the symptom dizziness) hits on a wounded person, and what response (R) is going to happen (, here "panic" feelings)? Along the sketch, we worked out different modes like the *happy*, *clever & wise, self-assertiveness* and *resources modes*, but also the *vulnerable & fearful child mode*. As the dysfunctional mode, that conceptualize the symptom, the patient would chose with a little smile the "*dying-mode*". When working closer with the latter we figured out three significant needs that was behind this mode: attachment, autonomy, and self-esteem. Attachment because he wanted to be emotionally close to a significant other, to be accepted with all his history and disabilities; autonomy since he felt deeply dependent on others (wheelchair), and now wanted to dominate others (Patient: *They shall do what I want*); and self-esteem since he needed desperately a good friend who would stick to him when peers are accusing him of "playing the dying swan". Early maladaptive schemas were – due to paraplegia - *vulnerability* and *defectiveness / shame* (depicted in Fig. 1 as "wounds"), which were explored from every aspect (memory, cognition, emotion, and body sensation), identified by its triggers (e.g. dizziness) and validated against the background of the accident early in life.

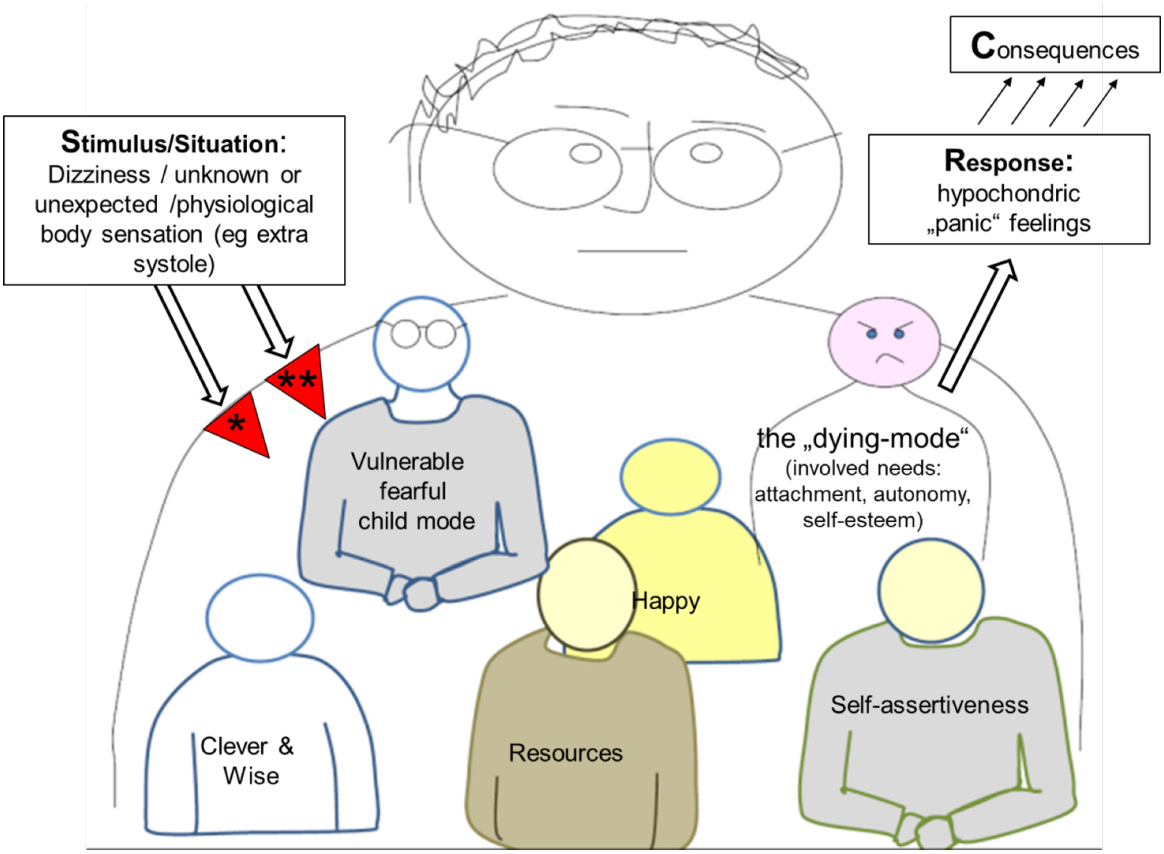


Fig 1: *Mode sketch with small figures as modes of the patient; according to Loose, Graaf & Zarbock, 2013, 2015, adapted from Schulz von Thun, 1999, figures created by Graaf). Maladaptive schemas are depicted as wounds, in this case vulnerability (*), and defectiveness/shame (**), which were triggered by the situation of harmless dizziness or similar bodily sensations.*

This model gave the patient a plausible, self-supporting, and individually tailored explanation why even harmless dizziness or other physiological sensations may have led to such deep fears, which could culminate at times in panic feelings of imminent death. The identified needs of attachment, autonomy, and self-esteem could in the next step (treatment phase 3, see below) be met more readily by the *clever & wise mode*, for example by speaking first on the inner stage with other inner team members (modes), then on the outer stage with parents, and peers about the need e.g. to be emotionally understood.

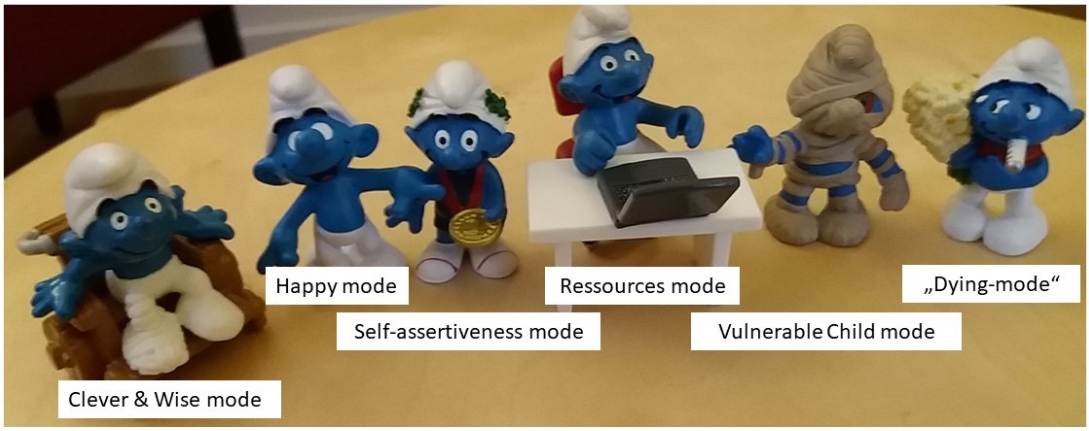
Treatment Phase 3: Mode work

In this phase 3 the patient selected for every mode one smurf, that would fit best previously defined mode's facets or properties. During this process, we allocated the mode properties to each selected smurf respectively, which allowed us in next step to obtain a first impression as to how the smurf team interacted with one other. Who was the boss (height of the smurfs)? Who liked whom or didn't (smurf's spatial distance from one another)? Who talked to each

Afterwards, we imagined the smurfs in different spots of the therapy room, although it was at that stage not yet clear whether classical chair work exercises would work at all, since the patient was in a wheel chair

other and who didn't (face direction of the smurfs)? And what happened, when all of the sudden a schema trigger like dizziness or any other body sensation appeared? What happened when peers were bullying him? The last two questions were addressed toward the appearance of the dysfunctional "dying-mode". Altogether, we freely talked and investigated in a playful manner each smurfs wishes, innate needs, emotions and jobs, in other words: the mode's function, including the pros and cons.

Afterwards, we imagined the smurfs in different spots of the therapy room, although it was at that stage not yet clear whether classical chair work exercises would work at all, since the patient was in a wheel chair, and could not simply change the chair. Would a change in position of his wheel chair in the room alone prove as helpful as the usual chair changing procedure? The answer is yes! Instructing and guiding the patient in his *clever & wise* mode to different locations in the room, we first validated, soothed and supported the *vulnerable & fearful* child mode by talking to him in a gentle, caring, and empathic way, recognizing and confirming his need for getting emotional support and warmth from the others. Moving from mode to mode, we allocated different messages to each smurf, thus giving each, that which was helping the vulnerable one to get its needs met, whilst simultaneously encouraging the happy mode to come more to the fore by contacting others to play play station with him for instance. The teenager's internal overly *self-critical* or *punitive mode* was perceived by the teenager as playing a minor role and for that reason was acknowledged by the therapist as such (highlighting the patient's autonomy), and therefore not conceptualized in the mode sketch. At the end, the patient could recognize and learn that



intense panic feelings were mainly schema-, and originally need-driven, and in most cases not precursors of life-threatening diseases. Again, being aware of the accident early in life and its impact (e.g. needing help in many day-to-day activities), and the emotional echo of it (feeling shame and emotional defectiveness) the schema-triggered response of experiencing intense, life-threatening anxiety, made a lot of sense. However, the chair dialogues were realized only by changing the wheelchair position and direction, and it worked impressively well.
By implementing further imagination exercises (e.g., *Trip to the clever & wise mode*), the patient was additionally supported in building up a stronger feeling of self-efficacy, for example , in addressing the *clever & wise* mode in order to help him overcome difficult moments in managing dizziness.

In the accompanying parental work, psychoeducational classical schema-mode-clashes between parents and patients were illuminated and concrete functional strategies for dealing with dysfunctional modes were developed.

Treatment Phase 4: Script, and Exposure (CBT-techniques)

After the clarification of the mode's inner dynamic (phase 2) and intervening on mode's level (phase 3), we then agreed in treatment phase 4 on distinct exposure exercises to check the feasibility and effectiveness of functional coping styles, in dealing with intense fears. For that reason, the parents were actively integrated in the therapy: What can they all do together when strong fears and panic thoughts arise? How could the parents support their son's capacity, to activate and move the *clever & wise* mode to the fore, so that the emotional needs are the focus of attention and not primarily the symptoms and demands? We worked out a future script that would enable the patient to feel close to the parents, here father, who is silently, empathically holding his hand, avoiding too much talking. Additionally, he needed to be allowed to feel autonomy by giving him the opportunity to calm himself down, whilst accompanying him rather than demanding him to stop, and increase self-esteem by helping him realize, that techniques from the therapy would indeed be effective when applied constantly (e.g. using an associated smell that was connected with the appearance of the *clever & wise* mode, using safe place and screen techniques to find some relieve from the intense aversive feelings and fears).

What can they all do together when strong fears and panic thoughts arise? How could the parents support their son's capacity, to activate and move the *clever & wise* mode to the fore

Homework exercises helped to deal with typical situations, strengthened the patient's and parent's

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
- Trauma
- 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

self-confidence, and consolidated the script's measures already prepared in the therapy. For school situations similar exercises were planned, prepared, and conducted, involving a classmate who was willing to provide support and who had attended a therapy session on one occasion.

Treatment Phase 5: Relapse prevention

The frequency and lengths of therapeutic sessions were gradually, and in agreement with patient reduced, repeating not only the script's details, but also resources, strengths, positive schemas from treatment phase 1 (relationship building), updating the explanation model from phase 2 (psychoeducation), practicing chair dialogues, and finally classical CBT-technique like exposure and self-assertiveness training procedures (phase 3 and 4), all accomplished by the patient's *clever & wise* mode.

Results: Sum scores of problematic behaviour in questionnaires like SDQ (Goodman, 1997) and depression inventory were assessed in a pre-post-12-monthsFU-design and yielded substantial improvement during the therapy and sustaining positive effects in the follow-up measurements. Additionally, the frequency of interruptions in the classroom 12-month after treatment's completion could be reduced significantly, and social integration improved substantially as well (meeting peers more frequently).

Summary: The combination of schema therapeutic, mode- and need-guided treatment on one hand, and CBT-procedures yielded lasting effects on a teenager's hypochondria symptoms with a relatively small number of sessions (24+6 for parents, each 50 min). Mode dialogues first with smurfs, and then with chair work exercises were possible in spite of the fact that the patient was confined to his wheel chair.

Outlook: Well-controlled, randomized studies are needed to further investigate the feasibility, acceptance and effectiveness of the schema therapy with and without CBT-approach on the child/teenager, but also on the parents, in order to find out what is helpful in breaking schema-triggered, dysfunctional behavioral patterns, and finding functional ways of coping with emotional wounds caused by past injuries.

Mad for Connection- A Case Study in Schema Therapy for Anorexia Nervosa

Dr Suzy Redston
Consultant Psychiatrist
Austin Health, Melbourne

** names in this article have been changed*

The following describes the case of a man referred for psychotherapy after years of various treatments for anorexia nervosa restrictive subtype both voluntary and involuntary.

The use of schema mode allowed the understanding of behaviours that were life interfering and until we adopted a schema mode approach had been managed by the patient (client) being obsessional about adherence to rules in all conditions and at the expense of all else.

Tom* had a childhood with every need unmet. He was a non-identical twin and although born first the needs of his physically weaker twin were prioritised in the first weeks of life.

Developmental Origins

Tom was born the 7th child of Elizabeth and the second of George.

He was a non-identical twin.

His Mother had married Frank and had five daughters, the eldest of which died in her youth. She then left Frank for George with whom she had five children, the last two died in-utero. This family of origin was chaotic and basic childhood needs were not met for any of the children. The girls stayed with their father but would visit their Mother when they wanted. The boys lived with their Mother in a two-bedroom home and the twins shared a bed in the lounge room sleeping on the same bed – top and tail.

George was an alcoholic who would disappear for months and return without warning. He was sexually abusive to his wife and Tom recalls hearing him raping his Mother, she would scream fir help, and Tom would try to get into the bedroom to help but the door had been

blocked by something heavy from the inside. From Tom's experience his Mother withdrew any vestiges of affection from when he remembers trying to save her and he, believed this was because he had been unable to save her.

Tom describes his father as being a figure in his life who abandoned him, abused him physically & verbally. However there were times when Tom would go and stay at his father's house to escape abuse at home.

His Mother was unhappy and provided no structure for the children. Tom wondered as an adult, that she was on strong tranquilisers to manage chronic anxiety & depression. He does not recall having any rules to follow (or break). She focused on the negative aspects of any external influences on her household and blamed others for all the problems she faced with day to day tasks, parenting and her own relationships. She was an absent Mother both emotionally and physically. She was leave her children for hours alone and return without explanation. There was never enough food or clothing for all the children and the home was filled with junk found on hard rubbish days, in charity shops or being given away. She was avoidant of any interactions with her children and Tom often felt he needed to shout at her to get her to notice him.

Tom and his twin were sexually assaulted by their older brother from a pre-adolescent until Tom left home at about 16 years-old and although his Mother knew, there was no limits set. A male neighbour had also assaulted Tom sexually, this man was asked to babysit and this re-enforced Tom's feelings that one of his roles in life was to satisfy the needs of others.

The food that was in the house was often well past the use by date and not enough for all the people living leading to constant competitions and fighting for food between the children. The boys were often sent to school in dirty clothes, without food and late even though the school was about 200 meters from the house.

At school Tom was often bullied and ostracized thus he developed habits of finding safe places to be during breaks one being under the school bell on a window alcove. Did not have a strong peer group at either primary or high school. Never felt he could let others know about his life at home.

Core Childhood Memories or Images

At about 7 being very hungry and his Mother was standing at the stove staring out the window. Tom holding onto the stove and yelling as loud as he could to his Mother that he was hungry. He does not recall how she responded but remembers feeling furious and un-contained.

Walking along a main shopping street in the inner city yelling abuse at his older brother who was walking on the other side. It was the brother who would sexually abuse him. Screaming out "you're a pervert" "you're an abuser" and knowing people were staring at him & looking across the road at his brother who was walking quickly and saying nothing. All the time Tom

knew that when he got home his brother would beat him & rape him yet felt powerful in the moment and liked the feeling. Was abused badly when he got home and his brother complained to Elisabeth that he had blood on his penis so she accompanied him to the hospital for a check-up. Tom was so furious because it was clearly from raping him that he decided he would move out if his Mother did not kick his brother out. When they returned nothing was said so Tom took his mattress and started to leave - his Mother tried to keep him by pulling on the mattress.

He eventually left that night and stayed living on & off the streets for about 5 years or more.

He also recalls many episodes of his Father & older brother ganging up on him calling him a sissy, as he was quite an effeminate young man. He identified as homosexual from as early as he can remember and this intra-familial stigma confused him.

When he was in transitional housing for at risk youth was told his Mother had died at home on the toilet. His older brother (who had abused him & his twin) had remained at home and had found her. He recalls being shocked & sad but also resentful that she had still allowed the most violent brother to stay while all the others had left and were in various forms of state care or on the streets.

With possible biological vulnerability to mental illness and addiction from both parents Tom having a serious life-threatening illness is not surprising.

Tom appears to have an assertive temperament and describes being always much more vocal than his twin. He was the first-born twin but smaller. Tom would also fight back and not surrender easily when his brother of father was abusing him physically. This leads me to think that he was born with quite a brave assertive temperament that wasn't allowed to evolve into a healthy adult but will be a great strength for his recovery as the maladapted modes are resolved.

Core Unmet Needs

From my understanding of Tom, his answers on the various Schema questionnaires and his core problems I think none of his basic childhood needs were met.

1. Secure attachment *(safety, stability, nurturance and acceptance)* Tom describes never feeling he was safe or accepted at home. He had a Mother who did not protect or nurture him and a Father that came and went without any predictability. As a twin he had also always had to share - first the womb & then the breast milk. Experience of neglect of all needs for a secure attachment.

2. Autonomy *(competence & identity)*. The bullying he experienced both at home & at school made it very difficult for Tom to establish his own identity. The constant criticism from others also challenged his sense of achievement and competence - even as a small child he was not given any sense of competence in normal childhood achievements.

3. Freedom to express emotions as there were no limits set on the behaviours of any of the children and no validation Tom has not got a sense of how to express emotions in an appropriate manner is very scared of exposing any vulnerabilities as his early life was so lacking in any nurturing. Rather he experienced verbal & physical abuse when he expressed any of his own needs or was completely ignored.

4. Spontaneity & Play it was not safe to be spontaneous or play even when a small child as his oldest brother was so violent and punitive with his siblings.

5. Realistic limits & self-control Finding a sense of self-control has been very difficult for Tom as he did not see it around him in his immediate family and, he has only truly found it with a severe eating disorder.

At the time of original referral and for the first two and half years of therapy were very difficult. Tom remained engaged mostly as he wanted to have a forum to ventilate how others were always failing him by not following rules.

Most Relevant Schemas

1. Mistrust and Abuse - abuse from immediate family members & people known to the primary care provider.

2. Abandonment - Both Mother & Father were experienced as abandoning him both emotionally and physically.

3. Punitiveness - developed as he needed to be hyper vigilant to reduce the abuse he was subjected to.

4. Emotional deprivation - Rejected from toddler by a father who came & went without any understanding by the children. His Mother appears to have been unable to give any emotional connections to her children and did not assist them to understand and learn their own emotional state.

6. **5.** Lack of self-control - Impaired limit setting by his Mother towards the behaviours happening between her sons, physical & sexual abuse. Not being sent to school with any guidance from home or capacity to be a part of the peer group.

Most Relevant Modes

1. Angry Child
2. Impulsive Child
3. Punitive Parent
4. Demanding Parent
5. Vulnerable child
6. Angry Protector

Overcompensating Behaviours:

1. Aggression and hostility Tom will be scathing and accusatory of people when he feels they have breached his confidentiality, autonomy or

broken a rule. He often will reduce people to tears or they walk off while he is still furious. This may also take the form of being hyper critical of others and being unable to consider alternative motivations for a person's behaviour other than the ones he has assigned.

He was able to stop needing rules and accept the complexity that is life – full of grey areas.

2. He will be the dominant sexual aggressor in his interactions.

3. Anger and fury with writer when a session starts late and interprets it as rejecting & disrespectful and will delay what he wants to talk about while he manages the anger.

4. Eating disorder is a mode that emerges when he is not feeling that others are hearing him as he needs.

The vulnerable child mode is often overshadowed by the angry/impulsive modes.I hypothesise that in the next few years there will be the emergence of some more child modes such as the vulnerable & lonely child but currently they are well protected by these more assertive modes.

Every twelve months of therapy I would ask Tom what he was goals of therapy were and he would always include "finding a life partner".

This was also always the most sabotaged goal outside of therapy by his behavious including avoidance.

Core Cognitions & Distortions

1. No-one will ever protect me so I must make sure I protect myself. I see all the potential criticism in what people do and say to me and I know I shall be negatively judged by others.

2. People are not following the rules and rules must be the priority, there are no exceptions. They must be held to account to me or else they disrespect me and are criticising me behind my back. When there are no rules the world becomes dangerous and chaotic. When I lived outside the rules I could not protect myself.

3. All people are going to reject me and let me down so I must reject them first.

Therapy Relationship

The therapeutic relationship with Tom has been difficult to establish and at times he has behaved in ways that have felt like he wants me to reject him. He has unleashed his angry child towards me as he assumed I had acted against him outside the therapeutic space. He

was so vicious and managed to attack me and trigger my own core anxieties. I was unable to contain him and I eventually cried in response to his relentless personal attack on me. I apologised and explained that this was in part in response to him building up to a dramatic permanent exit. However, it ended with him telling me "cancel all the further appointments as I cannot trust you" and I told him his appointments would be there for him. He returned the following week and there was a big shift in his approach to therapy and he began to let glimpses of his vulnerable and sad child into our space.

For Tom he wants to have a meaningful intimate relationship and possibly a life partner.

From this shift, we were able to put the angry child into the corner of sessions and work with the vulnerable child and soothe the parent modes. He was able to stop needing rules and accept the complexity that is life – full of grey areas. For the next twelve months or so the treatment was around allowing vulnerability into the space and experiencing this safely.

For Tom he wants to have a meaningful intimate relationship and possibly a life partner. Our focus was on helping him contain the angry child, angry protector and demanding parent by learning to notice the shifts, question if needed and ask himself "what do I need from this interaction". This continued into the near future and with imagery, role play and limited re-parenting we were able to uncover and soothe the sad and vulnerable child.

While working in schema mode approach over two years Tom was able to learn to soothe his child modes and developed a more adult approach to managing when these child modes were triggered.

We used imagery reconstruction, making sure the intellectual (avoidant self) is noted and asked to sit in an alternative chair and constant reparenting.

Finally this year he ceased therapy with no anorexia nervosa and has is working on a doctorate of philosophy (PhD) that brings together his past experiences as an involuntary patient in psychiatry hospitals for treatment of life threatening anorexia nervosa and his interests in ethics.

He is now dating and no longer therapy.

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