

# **Group Schema Therapy for Borderline Personality Disorder**

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**A Step-by-Step Treatment Manual  
with Patient Workbook**

**Joan M. Farrell and Ida A. Shaw**

**With additional chapters by: Arnoud Arntz, Heather Fretwell,  
George Lockwood, Poul Perris, Neele Reiss, Hannie van Genderen,  
Michiel van Vreeswijk and Jeffrey Young**

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# Contents

Foreword, Jeff Young	vii
About the Authors	xi
Acknowledgments	xv
1. Introduction <i>J. M. Farrell and I. A. Shaw</i>	1
2. The Conceptual Model of Group Schema Therapy <i>Joan M. Farrell and Ida A. Shaw</i>	8
3. Using the Therapeutic Factors of Groups to Catalyze and Augment Schema Therapy Interventions <i>J. M. Farrell and I. A. Shaw</i>	22
4. The Therapist Role: Limited Reparenting Broadened to a Family <i>J. M. Farrell and I. A. Shaw</i>	37
5. Some Basics of Group Schema Therapy <i>J. M. Farrell and I. A. Shaw</i>	79
6. The Course of Group Schema Therapy Stage One: Bonding and Emotional Regulation <i>J. M. Farrell and I. A. Shaw</i>	106
7. The Course of Group Schema Therapy Stage Two: Schema Mode Change <i>J. M. Farrell and I. A. Shaw</i>	143

8.	The Course of Group Schema Therapy Stage Three: Autonomy <i>J. M. Farrell and I. A. Shaw</i>	225
9.	The Patient Workbook Materials and How to Use Them <i>J. M. Farrell and I. A. Shaw</i>	244
10.	Combining Individual and Group Schema Therapy <i>Hannie van Genderen, Michiel van Vreeswijk, Joan Farrell, George Lockwood and Heather Fretwell</i>	265
11.	Meeting Core Emotional Needs in Group Schema Therapy Through Limited Reparenting <i>Poul Perris and George Lockwood</i>	271
12.	A Systematic Review of Schema Therapy For BPD <i>Arnoud Arntz</i>	286
13.	Conclusions and Future Directions for Group Schema Therapy <i>Neele Reiss, Joan Farrell, Arnoud Arntz and Jeffrey Young</i>	295
	Bibliography	302
	Index	307

# Foreword

I am very pleased to have been invited to write the foreword for this groundbreaking treatment manual on Group Schema Therapy (GST).

Since I first heard about the extremely positive results of the authors' randomized controlled trial of GST for patients with Borderline Personality Disorder (BPD) in 2008, I have been very excited about the potential of the group model to make schema therapy (ST) more available and affordable for patients. Given the worsening climate for mental health reimbursement in this era of managed care in the United States and elsewhere in the world, GST has the potential to deliver the powerful treatment strategies of the schema approach in a more cost effective manner than has been possible with individual ST – with equivalent or perhaps superior results.

When I met Joan and Ida for the first time at the International Society for Schema Therapy Congress, I was surprised to learn that they had been developing their GST approach for 25 years, and was struck by how many of the core components in my own work they had independently developed for their group approach. GST feels entirely consistent with my own individual model, in terms of the conceptual model, therapeutic alliance, and treatment interventions.

In the past, I had always been skeptical about the possibility of extending the intense therapy relationship I call “Limited Reparenting” – which is so central to the effectiveness of ST – to a group approach. I had always viewed group therapy as a “watered down” version of individual treatment, especially for patients with personality disorders. I was delighted to find that my preconceptions were entirely wrong. The GST approach Joan and Ida have developed is truly unique, exciting, and promising.

GST encourages group members to become like a healthy family in which they can “reparent” each other, under the watchful guidance of two highly

skilled therapist-parents. The sense of belonging and acceptance provided by this group analogue to a loving family seems to catalyze both the limited reparenting and emotion-focused components of ST.

Furthermore, by using two co-therapists for each group, GST has found a way to free up one therapist to move fluidly around the group, often working with one or two members at a time, creating novel experiential exercises to bring about change. At the same time, the second therapist serves as the “stable base” for the rest of the group, maintains an ongoing emotional connection with each member, monitors the reactions of all members, explains what is happening to educate them about what is taking place, and intervenes to shift the direction of the group to focus on the needs of other group members.

I am also impressed that GST goes well beyond traditional Cognitive Behavior Therapy/ Dialectical Behavior Therapy (CBT/DBT) group format, in which members are taught skills in a seminar-like setting; and non-CBT groups, in which the therapist does individual work with one member while the rest of the group primarily watches. In GST, the techniques used in individual ST, such as imagery change work and mode role-plays, have been adapted to engage all of the members in unique exercises that make use of the power of group interaction and support. These group therapeutic factors, combined with the broad range of integrative techniques that are already part of ST, may account for the large treatment effects in the controlled outcome study I mentioned earlier, as well as in preliminary data from other ongoing studies of GST.

This book is the first published treatment manual for GST, and succeeds in providing the most essential information clinicians will need to practice it. The authors describe a systematic approach to treating BPD patients in a group format, while retaining the flexibility that I have always valued so highly in developing individual ST. The treatment suggestions are specific and well-organized, with plenty of examples, while avoiding the temptation to write a therapeutic “cookbook” for therapists to follow in a rote manner.

To be more specific, the authors have preserved the core elements of ST by developing “limited reparenting” intervention strategies for each mode that arises in the group, seizing “experiential moments” to do emotion-focused work that brings about change at a deep level. Like individual ST, their group model blends experiential, cognitive, Interpersonal, and behavioral work.

This manual presents a step-by-step guide for GST with patients who have BPD. It includes a large selection of patient handouts, group exercises, and homework assignments – all presented in downloadable form on the

Wiley website for use with patients. The workbook material is arranged both by mode and by type of intervention, allowing therapists to choose the exercises and homework assignments that best match individual group members, and the therapist's own personal style. The user-friendly format of the book also provides sample therapist scripts, and numerous patient examples throughout.

The experience that the two authors have gained over 30 years of training therapists throughout the world, and leading GST groups with a broad range of clinical populations, is evident throughout the volume. The book is written at a level that should appeal to a very broad range of mental health professionals, including psychologists, social workers, psychiatrists, counselors, psychiatric nurses, as well as interns and residents.

On a more personal level, I had the opportunity to experience GST first hand as a participant at an advanced training workshop that I invited Joan and Ida to teach for the senior schema therapists at our New York institute. I am even more excited about the potential of ST in a group after this experience, and would love to conduct a ST group like this myself once I have learned the necessary skills.

Joan Farrell is an outstanding schema therapist who serves as the "stable base", emotional center, and "educator" for the group as a whole – a role I can imagine myself learning to fill, given enough time and experience. What truly amazed me – perhaps because her style is so different from mine and Joan's – was the remarkable group work of Ida Shaw. It is hard to convey the level of originality, creativity, and spontaneity she brings to the group experience. She is able to blend elements of gestalt, psychodrama, role-playing, and her own infectious style of play into an approach that perfectly fits the intensive demands of schema mode work, cajoling patients to change in profound ways. The group exercises in this manual will allow schema therapists to try out some of her unique work.

I see GST as one of the three most important advances since I began developing ST. It has served as a major impetus for international collaboration to further the development and dissemination of ST, including pilot studies in the Netherlands and Germany, as well as an intensive version for inpatient or day hospital use.

I am especially excited about the large-scale clinical trial that is underway at 14 sites in 5 different countries. Arnoud Arntz and Joan Farrell serve as the co-principal investigators of the study, testing the efficacy and cost-effectiveness of the GST model for BPD patients. This book includes the full treatment manual and patient materials used in the study.



Although this manual focuses on the treatment of patients with BPD, I believe that it also has great potential to be adapted for other patient populations, diagnoses, and treatment settings. Like individual ST, I expect the GST model (based on the principles outlined in this manual) to be effective for patients with other personality disorders (PDs), many Axis I disorders, and other chronic problems that have not responded to existing treatments. GST is already being explored as a potential treatment for patients with eating disorders, Avoidant PD, Dependent PD, Narcissistic PD, and Antisocial PD.

I want to personally thank the many members of the international ST community who have helped Joan and Ida in the refinement of the GST model and handbook. These include: Arnoud Arntz, Hannie van Genderen, and Michiel van Vreeswijk from Holland; Poul Perris in Sweden; Heather Fretwell and George Lockwood in the US; and Neele Reiss from Germany. These individuals have contributed chapters to this book that cover practical issues, such as combining individual and group ST; and more theoretical aspects, such as the chapter on needs and adaptive reparenting. The book also includes a meta-analysis of the studies that have been conducted to evaluate the efficacy of ST for patients with BPD; along with a chapter on the future of the group model, which I co-authored.

I highly recommend this outstanding manual to all mental health professionals working with more complex, chronic, and hard-to-treat patient populations – especially those who are looking for an evidence-based, cost effective alternative to existing therapies. This book is essential reading for professionals interested in ST, BPD and other personality disorders, group therapy, and in new approaches to expanding CBT. I commend Joan and Ida for their willingness to take risks in developing a truly creative and inspiring new approach to ST.

**Jeffrey Young, PhD**

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## About the Authors

*Joan Farrell, PhD, and Ida Shaw, MA, are the developers of the original Group Schema Therapy (GST) model and have specialized in the treatment of Borderline Personality Disorder (BPD) for 25 years. GST demonstrated its effectiveness in a randomized trial supported by a NIMH grant and was awarded the Governor's Showcase Award in Mental Health, Indiana. They developed an intensive inpatient program on a specialized hospital unit, which has promising pilot results. Currently they are the primary trainers and supervisors for a fourteen-site, five-country trial of GST and Dr. Farrell is co-PI with Professor Arnoud Arntz. Dr. Farrell is the Research and Training Director of the Center for BPD Treatment & Research (CBPDT&R), Indiana University School of Medicine-Midtown Community Mental Health Center, adjunct professor of Psychology, Indiana University-Purdue University Indianapolis. She was a clinical professor in Psychiatry Indiana University School of Medicine for 25 years where she received the Outstanding Faculty Contribution Award from the clinical psychology internship program and was honored by psychiatry residency classes for her teaching and supervision in BPD treatment. Ida Shaw, MA, is an Advanced Level Schema Therapist/Trainer and program consultant for CBPDT&R. She contributes expertise in experiential therapy and developmental psychology to GST. Together they direct the Schema Therapy Institute Midwest, Indianapolis and have been giving training in Schema Therapy (ST) and BPD treatment internationally for 20 years. They have published journal articles, a DVD series demonstrating GST and book chapters on BPD and GST and so far they have provided training to over 350 therapists from 12 countries in GST. They receive outstanding evaluations for their teaching and supervision, including the response that their enthusiasm and demonstrations inspire therapists to begin GST.*

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George Lockwood, PhD, clinical psychologist is the Director of the Schema Therapy Institute Midwest and a Founding Fellow of the Academy of Cognitive Therapy. He completed a post doctoral fellowship in CT under the supervision of Aaron T. Beck, MD in 1982, has training in psychoanalytic psychotherapy and object-relations approaches, and has Advanced International Certification in ST. Dr. Lockwood has lectured on CT and ST for 20 years and regularly receives excellent evaluations. He has written a number of articles on both CT and ST, has participated in the development of ST, contributed to "Schema Therapy: A Practitioners Guide", currently is serving on the board of the International Society of Schema Therapy, and has maintained a private practice for the past 25 years.

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*Hannie van Genderen, M. Phil. (psychotherapist/clinical psychologist), is employed at the Mental Health Center in Maastricht. She has trained in ST by Dr. Jeffrey Young since 1996. She closely collaborates with Professor A. Arntz of the Maastricht University, with whom she has written the book "Schema Therapy for Borderline Personality Disorder" (Wiley, 2009). She has trained in GST for BPD by J. Farrell and I. Shaw since 2009. She has been a trainer and supervisor in ST in the Netherlands since 2000. She is a member of the board of the International Society of Schema Therapy (coordinator for Training and Certification) and the board of the Dutch Schema Therapy Association.*

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*Jeffrey Young, PhD, is a clinical psychologist and psychotherapist who is the founder of ST. He directs the Schema Therapy and Cognitive Therapy Institutes of New York. He serves on the faculty in the Department of Psychiatry at Columbia University, is a Founding Fellow of the Academy of Cognitive Therapy, and is co-founder and Honorary President of the International Society for Schema Therapy. Dr. Young has led workshops for over 20 years, training thousands of mental health professionals throughout the world, including the US, Canada, the UK, Europe, Australia, China, South Korea, Japan, New Zealand, Singapore, and South America. He consistently receives outstanding evaluations internationally for his teaching skills, including the prestigious NEEI Mental Health Educator of the Year award. Dr. Young has co-authored two best-selling books with Janet Klosko, PhD: "Schema Therapy: A Practitioner's Guide" for mental health professionals, and "Reinventing Your Life," a self-help book for clients and the general public. Both have been translated into many languages.*

# Acknowledgments

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The therapists who trained with us have made important contributions to this treatment manual as teaching forced us to make explicit and clear the way we practice group schema therapy. They have also shared their creative ideas and feedback that led to improvements in our training model. Most of all we thank our patients, who taught us what we needed to understand about their needs and struggles and what worked to help them – the creative, intense, talented and at times challenging group of people with Borderline Personality Disorder. They stuck with us through the “group from Hell” when we were first testing our treatment ideas and continued to trust us through the 27 years of our developing the approach presented in this book. This treatment manual is dedicated to them.

Joan Farrell & Ida Shaw

# Introduction

J. M. Farrell and I. A. Shaw

This manual presents a step-by-step guide for Group Schema Therapy (GST) with patients who have Borderline Personality Disorder (BPD) along with a collection of handouts, group exercises, and homework to use with patients. It is the result of 25 years of work by Farrell and Shaw to develop an effective and comprehensive psychotherapeutic treatment for this group of severely disabled patients whose potential is tragically not realized in the quality of their lives. The authors' collaboration combined the training of Farrell in cognitive, personal construct, social learning, and psychodynamic treatment approaches with Shaw's training in developmental psychology and experiential approaches such as Gestalt therapy and bioenergetics into an integrative model for group therapy of BPD. Their initial approach was based upon their observation that BPD patients did not easily fit into traditional psychotherapy. For example, the patients they were working with were too distressed to stay in an office attending to the session for 50 minutes – they either dissociated or fled. In an effort to address this therapy-interfering behavior, Farrell and Shaw set distress reduction as the first goal. Patients were able to reduce distress enough to stay in sessions, but they did not use these techniques outside of sessions. This was understood as an inability to recognize pre-crisis distress levels – the point at which it is possible to use distress reduction most effectively. At the same time, Lane and Schwartz (1987) published an article presenting their theory of “levels of emotional awareness”, which they postulated as being parallel to Piagetian levels of cognitive development. This theory fit with the clinical observation



of BPD patients, who presented at early levels of emotional awareness – at best the global level where emotion is experienced as global extremes of good and bad. This construct parallels the dichotomous thinking observed in BPD. So, Farrell and Shaw's second treatment goal became increasing the level of emotional awareness patients had so that they could recognize pre-crisis distress. Accomplishing this required the use of experiential techniques including some at the level of kinesthetic awareness. Awareness work is consistent with Schema Therapy (ST) and remains part of the treatment described in this manual. Unfortunately, Farrell and Shaw found that even after their patients were able to notice pre-crisis distress, outside of therapy they still did not use the distress management or coping strategies they had been taught. Using a practical and collaborative approach, they asked the patients "Why?." The answer gave them the third goal of their initial program – schema change. Patient's answers were some form of "I am bad and deserve punishment, so it would be wrong to do good things for myself" or "I am helpless and life is hopeless, so why try?."

At about this point, Jeffrey Young's first book was published (1990). It became clear to Farrell and Shaw that someone else was struggling with the same dilemmas as they were with BPD patients and attempting to match treatment to the patient rather than vice versa. They identified the similarities in the theoretical model and the effort to integrate cognitive, behavioral, and experiential interventions in what Young was calling schema-focused therapy. Although they were not using the term, their approach had a limited reparenting focus from the beginning as they identified deficits in early emotional learning and failed attachment in BPD patients and the need to adapt traditional psychotherapy to deal with such deficits. The first name for their group work was "emotional awareness training" and they published an article describing it in the first issue of *Cognitive and Behavioral Practice* (Farrell and Shaw, 1994).

The first BPD treatment program that Farrell and Shaw wrote a manual for had three goals for patients: (1) to develop an individualized distress management and self-soothing plan and be able to use it effectively); (2) be able to recognize pre-crisis levels of distress and take action at that point; and (3) be free enough of maladaptive schemas to be able to take the actions of goals (1) and (2). The third goal was the most challenging as, like Young (1990), they used a definition of maladaptive schema that required change at not only the cognitive level, but also the emotional level. The original group treatment program consisted of 30 once-a-week, 90-minute group sessions designed to be an adjunct to individual psychotherapy. This

program was tested in a randomized controlled trial (RCT) supported by a National Institute of Mental Health (NIMH) grant that compared treatment as usual (TAU) individual psychotherapy (not ST, rather cognitive behavioral therapy [CBT] or psychodynamic) to TAU plus GST. The trial was conducted from 1991 to 1995 and is reported in Farrell, Shaw and Webber (2009). All patients were required to have been in their individual psychotherapy relationship (TAU) for at least six months, and stay in it for the course of the study and the six-month follow-up period. So essentially patients all received at least 20 months of weekly individual psychotherapy and half of them had the additional 30-session group program. The results (which are described in more detail by Arntz in Chapter 12: Systematic Review of Schema Therapy for BPD) demonstrated some of the largest treatment effect sizes published for a psychotherapy study.

The next development in the GST model occurred when a colleague, (Fretwell, a joint author of Chapter 10 in this book, who was a psychiatric resident with Farrell as a psychotherapy supervisor) attended a workshop with Young in 2003, and brought back information about a theoretical advance in ST – the schema mode. Modes are defined as the current emotional, cognitive, and behavioral state a person is in. The addition of the mode concept further integrated emotion into the understanding and treatment of patients with BPD. The idea that schema modes are triggered by events that patients experience as highly emotional and that modes can switch rapidly, resulting in the sudden changes in behavior or seemingly disproportionate reactions that plague BPD patients, aids both therapists and patients in understanding their experience and how to work toward change during therapy. The mode model captures the symptoms of BPD in user-friendly, understandable language for patients. Identifying the mode a patient is in also provides the foci for the type of therapist response required (e.g. validation versus empathic confrontation or limit setting). The mode concept was particularly important for psychotherapy with BPD patients who have high endorsement of almost all 18 maladaptive schemas. To focus instead on four or five modes is less overwhelming for both patient and therapist. Farrell and Shaw quickly incorporated this innovation by Young into their group work where it was particularly helpful as they moved on to develop an intensive version of the GST program for patients with severe BPD in inpatient settings. The intensive program incorporated the schema mode model for BPD of Young et al. (2003) adapted for group delivery. Uncontrolled pilot trials on an all-BPD inpatient unit demonstrated large treatment effect sizes for this longer program (Reiss, Lieb, Arntz, Shaw and

Farrell, in press). The original intensive model provided 10 hours of GST and one hour of ST per week with the average length of stay 18 weeks, thus a total of 180 hours of group and 18 hours' individual therapy. This is approximately equivalent to a year of outpatient treatment: two hours of GST per week with 18 individual sessions over a year. Whether GST delivered in a massed format in inpatient or day therapy, or over a year in traditional outpatient psychotherapy, is a question yet to be determined.

By the time they met Young and Lockwood in 2006, Farrell and Shaw realized that what they had developed was a group version of ST. In 2008, with Fretwell, they presented the results of their outpatient RCT and inpatient pilot study at the International Society of Schema Therapy (ISST) annual congress (Farrell, Fretwell and Shaw (2008). That presentation connected them with Arntz, who was planning a trial of ST in a group format. This resulted in a collaboration on the development of an international multi-site trial of Farrell and Shaw's model of GST in five countries at 14 sites with 448 BPD patients. This treatment manual is also the result of the ISST congress, where a work group was formed to produce a treatment protocol for the study chaired by Farrell, with Shaw and other senior schema therapists from four countries: the Netherlands – Arnoud Arntz, Hannie van Genderen, Michiel van Vreeswijk; Sweden – Poul Perris; USA – Heather Fretwell, George Lockwood and Jeffrey Young; and Germany – Neele Reiss.

The production of the treatment protocol and this book began by Farrell and Shaw sharing the original group model and manual (Farrell and Shaw, 1994; Farrell et al., 2009) with the work group. Using the work group's feedback from reviewing written drafts and observing demonstrations of GST in their training workshops, an extensive outline of the goals, stages, and therapist tasks of GST was developed. These outlines were tremendously helpful in the process of Farrell and Shaw's attempt to make explicit for the manual their practice of GST, which after 25 years of practice is implicit to the way they do GST. The work group contributed additional chapters from their areas of expertise in ST to produce a comprehensive treatment manual for GST. We benefited greatly from discussions with Jeff Young and his generous input about the adaptation of ST for group. George Lockwood and Neele Reiss were tireless in their editing of numerous drafts. Arnoud Arntz, as usual, was a great support in all ways. The process of writing this manual reflects the overarching collaborative and integrative style of ST as an approach to psychotherapy and life.

## **The Challenge of Producing a Manual that Represents the Flexibility of Schema Therapy**

An essential feature of the practice of Schema Therapy is that the therapist intervention match the mode the patient is in. This requires a good deal of flexibility on the part of the schema therapist in contrast to more regimented, skills training approaches such as Dialectical Behavior Therapy (DBT). Conducting ST in a group requires even more flexibility, as one is trying to match the modes of eight people and a ninth “person” – the group as a whole. In addition, the group therapist must harness the unique therapeutic factors of groups that are hypothesized to augment or catalyze the active ingredients of ST (Farrell et al., 2009) and to master the additional challenges the group modality presents. These critical elements require that a treatment manual and the patient materials for GST must be flexible and allow for matching the combination of modes that the group is in from moment to moment. In contrast, patients with BPD have typically grown up with the normal childhood need for predictability, supportive structure, and safety not being met. So, in addition to flexibility and seizing opportunities to make use of the healing aspects of group process, an effective ST group for BPD patients needs some amount of structure and predictability. The next requirement for a GST manual is that it provides enough structure and information so therapists using it can meet adherence requirements. Adherence is critical to being able to empirically validate a treatment in research trials. Adherence to a model is also what allows the positive results of the originators to be replicated in clinical settings. With the help of some of the senior schema therapists in the world, we have attempted to meet all of these challenges and requirements in this manual. Our plan is to have a manual that provides enough structure and predictability for patients to feel safe and for adequate adherence in treatment delivery to be possible, that also provides for the need to match intervention to group modes and attend to the group’s process and opportunities to harness its therapeutic factors.

## **The Manual Chapters**

The “how to” part of the manual begins with a brief description of ST, what remains the same in GST and what changes when ST is carried out in a

group. This includes a discussion of the adaptations to limited reparenting that the group model requires and Farrell and Shaw's development of the co-therapist team model for BPD treatment, adapting technique from individual ST to the group, descriptions of which interventions to use for each of the most frequent BPD modes, and how to take into consideration the stage of the group. The first nine chapters by Farrell and Shaw are intended to provide you with a step-by-step guide for conducting GST. This section is complimented by the patient materials available online.

The patient materials accompanying the manual (Chapter 9) were chosen from the 20+ year collection of material originally developed by Farrell and Shaw. All of the patient material has been tested in BPD patient groups and modified and refined based upon their responses and input and post-group discussions. It is being used as the protocol for the international multi-site trial of GST that is currently being conducted in the Netherlands, Germany, the US, Scotland and Australia at 14 separate sites. Therapists will be able to choose from the exercises, handouts, and homework of the manual based upon the goal they are focusing on, the assignments and exercises that best fit the mode of their group, and the stage of treatment that the group is in. Patients can assemble the material selected for them into a workbook that will be unique to their ST group. Practitioners new to ST can follow closely the recommended session order with corresponding patient materials, while experienced schema therapists can create their own order of preference. Cognitive therapists can try out the experiential exercises provided and experiential therapists can make use of the cognitive and behavioral techniques also provided in the manual. Group therapists with no ST training can explore the ST conceptual model and try out the group exercises developed for and tested on BPD patients.

Chapters 10 through 13 address other important applications and issues of GST. In Chapter 10 the issues involved in combining individual and group schema therapy are discussed with case examples by van Genderen, Lockwood, van Vreeswijk, Farrell, and Reiss. Peer supervision is included in this chapter given the important role of a team approach to the coordination of the two modalities. Chapter 11 by Perris and Lockwood addresses the use of emotional need as a compass for adaptive reparenting interventions by schema therapists. They take the mode matching axiom of ST even further with practical descriptions of what adaptive reparenting looks like based upon schema and need domain. The acknowledged leader of ST research, Arntz, describes the effectiveness of research for GST in Chapter 12.

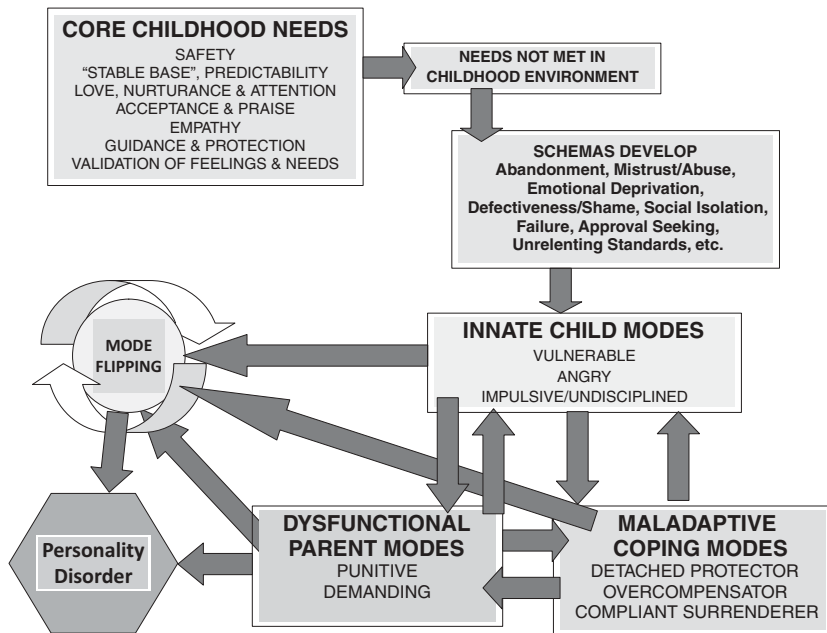
Keep in mind that this manual addresses the GST treatment needed for BPD patients. The various techniques and the reparenting style described in this manual address the modes, underlying needs, and developmental level of BPD patients at various stages in an 18- to 24-month treatment process. They will fit patients who are similar on those three dimensions, whether they have a BPD diagnosis or not. Patients with different disorders will have different sets of needs at various developmental levels, and GST can be adjusted accordingly. An underlying axiom of all ST is that the intervention must match the patient and their mode. A healthier and more functional patient group may need a group of peers in which much of the reparenting is done by the group itself, with guidance from one therapist, rather than a “surrogate family” with two parent–therapists leading it. In Chapter 13, Reiss, Farrell, Arntz and Young discuss the application of the GST model to other patient groups and what they see as the future of GST.

Young has described GST as a third stage in the development of ST (Roediger, 2008). This third stage is not only an innovation with respect to ST content, but also has been a major impetus for international collaboration for the further development and dissemination of ST. The group model of ST holds important promise with the public health dilemma of our time – a way to make an evidence-based treatment widely available for BPD (and potentially other severe disorders). Like individual ST, we expect the group ST model developed by Farrell and Shaw to be adapted effectively for other PDs and Axis I disorders and chronic problems that have not responded to other treatments.

# The Conceptual Model of Group Schema Therapy

Joan M. Farrell and Ida A. Shaw

The Group Schema Therapy (GST) model presented in this manual is consistent with the theory, components of treatment, and goals outlined for individual Schema Therapy (ST) by Young, Klosko & Weishaar (2003) and the Arntz & van Genderen (2009) publication of the treatment protocol from the successful trial in the Netherlands (Giesen-Bloo et al., 2006). Schema Therapy's conceptual model for Borderline Personality Disorder (BPD) will be briefly summarized here and the reader is referred to those volumes for additional elaboration of the individual ST model and its application. ST is an integrative treatment with roots in Cognitive Therapy (CT), learning theory, and the research of developmental psychology. ST grew out of efforts by Young and associates to treat more effectively patients with personality disorders and those who either did not respond to traditional CT or relapsed. As the name suggests, the focus of ST is at the schema level. This requires a shift from present-day issues to lifelong patterns, an adaptation required for personality disorder work. ST is based upon a unifying theory and a structured and systematic approach. ST concepts have some overlap with CT, psychodynamic psychotherapy, object relations theory, and Gestalt psychotherapy, but they also differ in important respects and have total overlap with no other model. The goals of ST reach beyond teaching behavioral skills, including the fundamental work of personality change. This change is conceptualized as involving decreasing the intensity of maladaptive schemas that trigger under- or over-modulated emotion and action states referred to as modes. The triggering of these intense states is seen as interfering with the use of adaptive coping or interpersonal skills by



**Figure 2.1** Schema therapy model. Etiology of personality disorder

patients that would allow them to realize their potential and improve their quality of life. Schema Therapy's Hypothesized Etiology of BPD.

Figure 2.1 summarizes the model for the etiology of BPD posited by ST. When the normal, healthy developmental needs of childhood are not met, maladaptive schemas develop. Maladaptive *schemas* are psychological constructs that include beliefs that we have about ourselves, the world, and other people, which result from interactions of unmet core childhood needs, innate temperament, and early environment. They are composed of memories, bodily sensations, emotions, and cognitions that originate in childhood and are elaborated through a person's lifetime. These schemas often have an adaptive role in childhood (e.g., in terms of survival in an abusive situation – it engenders more hope for a child if they believe they are defective as opposed to the adult being defective). By adulthood, maladaptive schemas are inaccurate, dysfunctional, and limiting, although strongly held and frequently not in the person's conscious awareness. Nineteen early maladaptive schemas (EMS) were identified in patients with personality disorders (Young, 1990; Young et al., 2003). The original 15 are organized



**Table 2.1** Schemas organized by content area

<b>Disconnection and Rejection (Connection and acceptance)</b>	<b>Impaired autonomy and performance (Autonomy and performance)</b>
Mistrust/abuse	Dependence/incompetence
Emotional deprivation	Vulnerability to harm/illness
Defectiveness /shame	Enmeshment/undeveloped self
Social isolation/alienation	Abandonment/instability
Emotional inhibition	Subjugation
	Failure
<b>Impaired limits (Adequate limits)</b>	<b>Exaggerated expectations (Realistic expectations)</b>
Entitlement	Self-sacrifice
Insufficient Self-Control	Unrelenting standards

around four content areas: I Disconnection and rejection; II Impaired autonomy and performance; III Impaired limits; IV Exaggerated expectations. The three which were added more recently – negativity, punitiveness, and approval seeking – are not included in the table as there is not yet an empirical basis for placement or their existence as separate factors.

When maladaptive schemas are triggered, intense states occur that are described in ST as “schema modes.” A schema mode is defined as the current emotional, cognitive, and behavioral state that a person is in. Dysfunctional modes occur most frequently when multiple maladaptive schemas are triggered. Four basic categories of modes are defined (Table 2.2).

Primary **Child modes** (Vulnerable Child, Angry Child, Impulsive Child) are said to develop when basic emotional needs in childhood (such as safety, nurturance, or autonomy) are not adequately met. These innate “child modes” are defined by intense feelings such as fear, helplessness, or rage, and involve the innate reactions a child has. **Dysfunctional Parent modes** (Punitive Parent or Demanding Parent) comprise the second category of modes. Dysfunctional Parent modes reflect the internalization of negative aspects of attachment figures (e.g., parents, teachers, peers) during childhood and adolescence. Labeling these modes “parent” is not intended to blame parents for BPD symptoms. Parents have their own schema and mode issues and may have deficits in the parenting they experienced and, consequently, impaired parenting ability. According to a review by Zanarini &

Table 2.2 Schema modes, their role in BPD, relationship to BPD symptoms

<i>Role in BPD</i>		<i>Related BPD Symptoms</i>
<b>Child modes</b>		
Vulnerable Child Experiences intense feelings, emotional pain and fear, which become overwhelming and leads to flips into Maladaptive Coping modes that are identified as other BPD symptoms	Intense, uncomfortable feelings – emotional pain and fear become overwhelming and lead to flips into Maladaptive Coping modes that are identified as BPD symptoms	Abandonment fears, real or imagined
Angry Child Vents anger directly in response to perceived unmet core needs or unfair treatment	A source of problems with others since anger is not just about present trigger, it is seen as inappropriate and misunderstood	Intense inappropriate anger Stormy relationships Emotional reactivity
Impulsive Child Impulsively acts based on immediate desires for pleasure, without regard to limits or other's needs (not related to core needs)	Also a source of interpersonal, work, legal problems. Action is usually self-damaging or potentially so	Difficulty controlling anger Self-injury Impulsivity that is potentially self-damaging Unstable sense of self
<b>Maladaptive Coping modes</b>		
Avoidance Pushes others away, breaks connections, emotional withdrawal, isolates, avoids	Most common in a continuum from “spacy” to severe dissociation or physical withdrawal. Can be in the form of pushing others away via anger – the Angry Protector	Emptiness Dissociation Unstable identity

(Continued)

**Table 2.2** (Continued)

	<i>Role in BPD</i>	<i>BPD Symptoms</i>
Overcompensation Coping style of counterattack and control. Sometimes semi-adaptive	Common – Bully-Attack mode	Intense inappropriate anger Difficulty controlling anger
Surrender Compliance and dependence – gives up own needs for others, people pleasing	Common and often overlooked as can flip quickly to overcompensation	Unstable sense of self Emptiness
<b>Dysfunctional “Parent” Modes</b>		
Punitive Restricts, criticizes and punishes self and others	Very common, can be a source of self-injury or suicide attempts	Suicide gestures or attempts
Demanding Sets high expectations and level of responsibility, pressures self/others to achieve	Common also, origin of defectiveness, unstable sense of self	Suicide gestures or attempts Unstable sense of self
<b>Healthy modes</b>		
Adult Is able to meet needs in healthy way Happy Child Feels loved, connected, content	Underdeveloped  Often non-existent	Unstable identity Emptiness Unstable identity Emptiness,
<b>Mode flipping</b> Frequent, exhausting, feels “crazy” and confusing to self and others	Can account for instability affect, behavior, interpersonal, identity Transient psychosis	Emotional reactivity Unstable identity Stress-related psychotic states

Frankenburg (2007), studies report a high rate of sexual abuse – 40–70% depending upon the study. Herman, Perry & van der Kolk (1989) found that 81% of patients diagnosed with BPD report physical, sexual or emotional abuse in childhood from some significant caretaking figure. Lobbestaël, Arntz & Sieswerda (2005) and Arntz et al. (2005) explored the empirical relationship between schema modes and childhood sexual abuse. Temperament and childhood environment interact to produce the modes of BPD patients. However, rather than the traditional stress-diathesis model used in most approaches (e.g., Dialectical Behavior Therapy, DBT) where stress impinges on a vulnerability based in temperament, ST views this interaction in terms of a plasticity or differential susceptibility model. This model suggests that a patient with BPD has qualities, such as being highly sensitive and reactive to the environment, which can lead to very bad outcomes when exposed to toxic or insensitive parenting, and exceptionally good outcomes in the context of highly responsive and nurturing parents (Lockwood & Perris, 2012). Whatever the reason for it, failed or insecure attachment is hypothesized as the cause of emotional dysregulation in BPD. When a patient is in a Dysfunctional Parent mode they experience self-devaluation, self-hatred, and/or they put extremely high pressure upon themselves. These feelings may also be directed at others – that is, the person in Punitive Parent mode is punishing and judgmental to others as well as or instead of himself or herself.

**Dysfunctional Coping modes**, a third category of modes, are defined by an overuse of unhealthy coping styles (fight – overcompensation, flight – avoidance, or freeze – surrender). All have the goal of protecting the Vulnerable Child mode from further pain, anxiety, or fear. They operate without conscious choice before and at the beginning of therapy. Dysfunctional Coping modes incorporate the concept of defense mechanisms, a concept previously missing in CT, and allow for a better understanding of personality disorders. The overcompensation coping style contains modes in which a person acts directly in opposition to the schema that is triggered. An example is the Bully-attack mode in which perceived hurt is retaliated against. The Avoidant coping style includes the Detached Protector mode, a hallmark of BPD that ranges from being “spacey” or briefly losing focus in an interaction to severe dissociation. BPD patients typically enter therapy in Detached Protector mode, which operates to protect the Vulnerable Child mode from overwhelming or painful feelings. Surrender is the third coping style and it represents giving in or giving up to the schema present.

For example, if the triggering schema is defectiveness, a surrender response would be to accept that you are defective and behave accordingly – never taking on challenges, working to not be exposed as incompetent.

In a fourth category, **Healthy modes**, the Healthy Adult mode and Happy Child mode are found. The Healthy Adult mode includes functional thoughts and balanced behaviors, and the Happy Child mode is a resource for playful and enjoyable activities, especially in social networks. The Healthy modes are severely underdeveloped in BPD patients. Modes are often triggered by events that patients experience as highly emotional. Modes can switch rapidly in patients suffering from severe personality disorders such as BPD, resulting in the sudden changes in behavior or seemingly disproportionate reactions that are one source of patients' interpersonal difficulties.

The schema modes hypothesized for BPD patients by Young et al. (2003) have been empirically validated by the work of Lobbestael, van Vreeswijk & Arntz (2008). The DSM-IV-R criteria for BPD, which refer to the symptoms thought to define the disorder, can be understood in terms of the schema modes common in BPD patients. Table 2.2 displays these relationships. In summary of the relationship between diagnostic criteria and modes: Abandonment fears describe the emotional state of the Vulnerable Child mode. Intense anger, at times accompanied by uncontrolled expressions of anger, occurs in the Angry Child and Impulsive Child Modes. The Impulsive Child Mode fuels action that is potentially self damaging as well as being one source of self-injurious behavior. The Dysfunctional Parent modes (Punitive or Demanding) are another source of self-injurious behavior, to fulfill their dictate that the child deserves punishment or is a failure. Patients with severe BPD even experience the parent modes as "voices" commanding them to punish themselves. The parent modes can also be a source of suicide attempts as they remove all hope and their judgments condemn the patient to misery and feelings of worthlessness. The Detached Protector Coping mode can be a cause of self-injurious behavior, particularly cutting or burning the skin, in order to feel something. The Detached Protector mode explains the BPD criteria of emptiness and unstable sense of self. This emptiness can be intolerable and lead to suicide attempts. If you are detached from your feelings, a central part of who you are, your identity, will not be stable. Impulsivity also contributes to an unstable sense of self as the BPD patient experiences her/himself as inconsistent and unpredictable.

Mode flipping is the explanation from ST theory for the transient stress-related psychotic experiences (usually paranoid in nature) or severe dissociation that are seen in BPD, and constitute one of the DSM-IV-R criteria for assigning the BPD diagnosis. Mode flipping accounts for some of the emotional reactivity seen in BPD patients and consequently their unstable relationships. The mode model presents the symptoms of BPD in user-friendly, understandable language for patients and provides the foci for psychotherapeutic intervention for therapists. As discussed in more detail in Chapter 7, the mode the patient is in determines the therapist response required. Child modes require validation, nurturance, and support with empathic confrontation and limit-setting for the Angry and Impulsive modes while still finding ways for the needs underlying those modes to be met more effectively. Empathic confrontation is defined as the therapist's approach to early maladaptive schemas and dysfunctional mode behavior, with empathy for how they developed, balanced by confronting these behaviors as needing to change for the patient to have a healthy life. Empathic confrontation is only effective in the context of a limited reparenting bond with the patient. Coping modes need to be identified and evaluated as to whether the outcomes they produce meet the underlying need present in the patient. Parent modes need to be identified and understood as separate from the self. Their faulty dictums must be challenged and either banished if Punitive Parent mode or modified to be realistic if Demanding Parent mode. Healthy modes – Healthy Adult and Happy Child – are the antidotes for the maladaptive and dysfunctional modes and they are developed and encouraged in ST by validating competence and encouraging play. Play and the Happy Child mode are seen as crucial to encourage in ST as play is an important missing learning experience for BPD, both in terms of learning about oneself by exploring the environment (e.g., discovering what experiences you like and dislike) and the interpersonal learning about relating to others that play provides. The importance of play is referred to often for adults by the question of whether or not one knows how to “play well” with others. Matching the patient's mode with therapeutic intervention and stance is essential, as it is central to the therapist's connection to the patient. It is a reflection of the therapist's ability to recognize at a deep level where the patient is and who they are at that moment. This matching is more of a challenge in GST since there are more patients to match, but it is no less important. This essential therapist task is one of the reasons that we see BPD groups as requiring two therapists; one who can attend

to the group as a whole, their modes, process, and involvement in the current therapeutic work, while the other therapist leads the part of the work that has an individual focus. The co-therapist model is elaborated in Chapter 4.

## Goals of Group Schema Therapy

Young summarizes the primary goals of treatment of ST as helping patients change dysfunctional life patterns and getting their core needs met in an adaptive manner outside of therapy, by changing schemas and modes. The goals for BPD patients in terms of schema mode change are described as follows.

Develop the Healthy Adult mode so that she/he is able to:

1. Care for the Vulnerable Child, so that a healthy adult is present when fear or loneliness are triggered, reflecting a child level need that was not met.
2. Reassure and replace the Detached Protector mode: reassure that feeling the emotion present will not overwhelm or destroy the self, and replace with healthy coping skills that can be chosen at times when emotions run high. Choice of level of detachment takes place rather than the person defaulting to detachment instead of making a conscious choice.
3. Teach the Angry Child appropriate ways to express emotions and needs, that is, the ability to express needs in an assertive appropriate manner.
4. Overthrow and banish the Punitive Parent: get rid of the harsh internalized critic, replacing it with the ability to motivate oneself in a healthy supportive manner, accept, and – when needed – make retribution for mistakes.

We add a fifth goal:

5. Free the Happy Child mode so that she/he can explore the environment and learn about what gives her/him joy in life.

The interventions of GST that produce these changes in schema modes are described in detail in Chapters 4 through 9.

## **The Therapy Relationship in Schema Therapy**

The therapist in ST must offer not only a collaborative adult relationship, as in most psychotherapy models, but also a parenting relationship to the client's child side. This is seen as necessary to correct dysfunctional schemas based upon unmet needs and to allow healthy new schemas to form in the context of a healthy reparenting relationship in therapy. According to Young this would involve finding out what basic emotional needs were not met in childhood and meeting them to a reasonable degree in therapy (Young, 1990; Young et al., 2003). The term "limited reparenting" describes the therapists' caring attitude towards their clients, acting as a "good parent" would early in therapy, in particular when dealing with the Child modes. In experiential work with the Vulnerable Child the therapist provides validation and nurturing within the bounds of a professional relationship. Limited reparenting has been the source of some controversy and misunderstanding. The basic position of ST is that patients who experienced depriving and/or abusive early caregivers must experience positive parenting before they can learn to do this for themselves. A person needs to have the experience of core needs being met to know how to meet them for him/herself as an adult. The goal of ST is autonomy, so this early focus on the therapist doing the reparenting is ultimately replaced by a developed and strengthened Healthy Adult mode where the patient performs these functions (e.g., self-soothing, assertive requests). Reparenting targets the need of the mode the patient is in, so the Angry or Impulsive Child modes are provided with the empathic confrontation or limit-setting needed in those modes. The therapist in ST is also active in helping the patient replace maladaptive Coping modes like detachment with more adaptive coping, and in assisting the patient in banishing the Dysfunctional Parent modes. This empathic, active involvement, and modeling by the therapist is termed "limited reparenting." The changes in the therapist role that are required in GST for BPD are described in Chapter 4.

## **Structural Model of Group Schema Therapy**

Therapy groups can be organized into three basic types: Interaction or Process; Person-oriented; and Psychoeducation, disorder-specific. Sipos and Schweiger (2009) raised the important question of "what model is GST?" Like ST, GST integrates aspects of all three types, but has total overlap with none of them. Table 2.3 describes the models.



Table 2.3 Models of group therapy

<i>Model</i>	<i>Examples</i>	<i>Goals</i>	<i>Therapist role</i>	<i>GST comparison</i>
Interaction or Process group	Interpersonal groups (Yalom)	Change problematic behaviors using group dynamics.	Outside of the group	Uses group dynamics as a source of change (group therapeutic factors) Therapist is part of group and actively leads and directs members
	Psychoanalytic groups Encounter groups (Rogers)	High emotions and conflict are desired	Stimulates interaction, but does not guide it All can start interaction at any time	
Person-oriented Group	Gestalt (Perls)	Work on individual needs and goals	Focus on and support the protagonist	Work is done on individual needs and goals, but always linked back to shared themes (e.g., a mode) Members aid in individual work and join into the work Attention to group process is prioritized over instrumental conditions Aid among members is mutual
	CT (Beck) Psychodrama (Moreno) Problem-solving Therapy (D’Zurilla)		Foster instrumental group conditions Structure the session Members aid protagonist in their goal	

Psychoeducational or Disorder-specific Group	Manualized group therapy for specific disorders (e.g., depression, anxiety, BPD)	Knowledge and skills Empowerment (become an expert on own illness)	Teaching information Teaching skills Structure the session Guide the group Focus on the “middle patient”	Psyched and guidance are provided in child modes Rather than a “middle patient” – attention to all patients’ needs and goals are balanced Experiential work is prioritized over skills
Group Schema Therapy Combines aspects of all three with total overlap with none	GST for BPD (Farrell & Shaw)	Schema mode change that allows changes in dysfunctional life patterns and enables getting one’s core needs met in an adaptive manner	Conduct the group in a manner that harnesses group process and therapeutic factors Act as a Good Parent matching group’s developmental level Encourage group members participation in “familial” learning	All of the above are aspects of GST

A caveat is that in doing GST it is important to make sure that when you are making use of group process and encouraging group interaction, you are an active leader, not the “outside of group” facilitator of the interpersonal process group model. Part of the goal of the interpersonal model is to heighten conflict. This is not a goal for a BPD group. In our first training workshop we did not make the needed structural model clear enough to participant therapists, so their first group role-play ended in chaos with some participants who were playing patients running from the room in anger or fear and group conflict of unmanageable proportion. When this misperception was corrected, the next role-play led to the cooperative cohesive group that we are accustomed to since the “therapists” in the role-play were then able to establish and maintain this more effective environment.

The major difference between GST and the other group models is that GST is integrative and combines what we see as the core components or active ingredients of process or interpersonal groups with the inclusion of cognitive, experiential, and behavioral pattern-breaking work of the more instrumental groups. GST is both process and task oriented, making use of the best of these two “worlds” of psychotherapy. Other approaches to BPD treatment either focus on skills with little attention to group process and dynamics (e.g. DBT – Linehan, 1993; STEPP – Blum et al., 2008) or if process oriented, exclude BPD patients as poor candidates (Yalom & Leszcz, 2005)

We see this neglect of using group process and therapeutic factors by other BPD treatments as a significant missed opportunity for other BPD treatments and as one potential reason for their lower treatment effects compared to GST. If you use the group modality, but only do individual therapy or skills training while a group of patients watches, it may be cheaper in terms of health care cost (not considering the other societal and family costs), but will be a less potent version of individual therapy. When a treatment for BPD (or other personality disorders) is delivered in a group, it is more efficacious to recognize that the group is there and take advantage of its unique therapeutic factors. As previously stated, the group itself can be healing for the main schemas of BPD that relate to connection and belonging. The neglect of these opportunities for interpersonal work and the relative neglect of the later stages of emotional and social development, by other BPD treatments may be one reason for their limited effects on measures of global function, relationships, and quality of life (Zanarini, 2009). Lack of attention in other treatments to these important aspects of life gives rise to the complaint of BPD patients that they may not self-injure or

attempt suicide, but are still miserable, not in healthy relationships, and are underemployed with an inadequate quality of life (Van Gelder, 2008; and the personal accounts of many patients entering ST treatment).

In conclusion, the conceptual model of ST has been validated in a number of studies (Loebaestel, et al., 2008; Reiss, et al., 2011) and growing evidence for its clinical and cost effectiveness for the individual modality (Giesen-Bloo et al., 2006; Nadort et al., 2010). There is evidence as well for the effectiveness of the Farrell and Shaw GST model (Farrell et al., 2009; Reiss et al., under review).

# Using the Therapeutic Factors of Groups to Catalyze and Augment Schema Therapy Interventions

J. M. Farrell and I. A. Shaw

## **The Group Modality may Augment and even Catalyze Schema Therapy**

How do we explain the large treatment effect size resulting from the relatively short 8 months of Group Schema therapy (GST) in the Farrell et al. (2009) study? One explanation is that ST, independent of the modality used (i.e. individual or group), is a distinctly efficacious treatment for Borderline Personality Disorder (BPD) with treatment effect sizes that are larger than those reported by the other main BPD treatment approaches (including Dialectical Behavior Therapy, Transference Focused Psychotherapy, Mentalization Based Treatment, Cognitive Therapy as summarized Arntz, 2010) (Giesen-Bloo et al., 2006; Nadort et al., 2010). However, the treatment effect sizes from the Farrell et al. (2009) trial are even larger than the individual ST effect sizes even though the length of the treatment was much shorter (8 months of weekly ST group added to non-ST weekly individual psychotherapy (that continued for 6 months post-treatment) versus 3 years of individual ST 1–2 times per week). Additional pilot studies of combined individual and group ST, outside of the developer's site (conducted in the Netherlands) demonstrate comparable large effects. (The studies referred to here are all described further in Chapter 12 Systematic Review of Schema Therapy for BPD.)

Another explanation of the dramatic improvement in the “Group GST added condition” is simply that ST delivered in a group format provides something different or adds something to individual psychotherapy even when the individual psychotherapy is not ST. ST may possess amplified

effectiveness when it is delivered in a group modality owing to specific factors present in a group that augment and even catalyze ST interventions and active ingredients. Factors unique to GST that are thought to contribute to the group's effectiveness include: mutual support, validation by and relationships with group members, the possibility to safely experiment with emotional expression and new behaviors in the group, mutual attachment that might heal unsafe attachment representations, and empathic confrontations that group members give each other. The expansion of limited reparenting from the dyad of individual ST to two "parents" and an entire "family" adds additional interpersonal corrective emotional experiences (elaborated in Chapter 4 *The Therapist Role: Limited Reparenting Broadened to a Family*). The group modality expands the creative options possible for healing the child modes. A group can create collective soothing blankets in imagery or reality that they share when doing imagery re-scripting with the Vulnerable Child mode. "Fun" anger release work for the Angry Child mode can be done more safely in the group, and possibly with less embarrassment as other people are involved. Many creative play opportunities are available for the Happy Child, a mode relatively undeveloped in BPD patients. Patients sometimes seem to feel less "silly" playing in a group of peers than one-on-one with their therapist. The group adds a larger cast of possible players for experiential techniques including mode-role-plays, full-chair work, or psychodrama. The group provides a naturalistic "laboratory" for missed attachment experiences where maladaptive schemas and modes can change through the experience of limited reparenting from the therapists and the group "family."

Farrell et al. (2009) suggest that the therapeutic factors of well-run groups directly impact the main schemas of BPD patients by providing a sense of belonging and acceptance, and that the closer analogue to the primary family that group provides strengthens the reparenting and experiential learning components of ST. That is, if ST interventions such as imagery work and mode role-plays are adapted to include the group as a whole in order to make use of the power of the group rather than conducting individual interventions while the group watches.

### **Group Therapeutic Factors can Amplify Schema Therapy Interventions**

One of the amplifying effects of GST is the interaction between core BPD symptoms like abandonment, lack of belonging, mistrust of others based

**Table 3.1** Therapeutic factors of group and primary schemas and modes impacted

<i>Group therapeutic factors</i>	<i>Primary schema impacted</i>	<i>Primary mode impacted</i>
Cohesiveness/belonging	Abandonment	Vulnerable Child
Corrective recapitulation of primary family	Mistrust/abuse	All Child modes
Corrective emotional experiences	Emotional deprivation	
	Vulnerability to harm/illness	
	Subjugation	
	Self-sacrifice	
	Approval seeking	
Universality	Defectiveness/shame	Vulnerable Child
Instillation of hope		
Compassion/altruism	Punitiveness	Parent modes
Imparting of information	Unrelenting standards	Parent modes
	Dependence/ incompetence	
	Failure	
Catharsis	Emotional inhibition	Coping modes
Play, spontaneity		
Development of socializing techniques	Social isolation/alienation	Coping modes
Interpersonal learning	Enmeshment/undeveloped self	Healthy Adult mode
Vicarious learning		
Existential factors		

upon childhood abuse, stormy relationships, emptiness, defectiveness, and the therapeutic factors of therapy groups described by Yalom & Lezcz (2005). Table 3.1 displays this hypothesized interaction.

GST makes strategic use of the therapeutic factors thought to occur in well-run therapy groups, namely: instillation of hope, universality, altruism, experience of group cohesiveness, corrective recapitulation of the primary family, opportunities for emotional catharsis, added information sources, modeling, vicarious learning, interpersonal learning, in-vivo desensitization, and social skill practice opportunities. These therapeutic factors are

woven throughout GST and are strategically harnessed to assist the primary goals of ST – helping patients change dysfunctional life patterns and get their core needs met in an adaptive manner outside of therapy, by changing schemas and modes.

### *Cohesiveness and belonging*

Our BPD groups tend to be very cohesive and often refer to themselves spontaneously as a “family.” We foster this group cohesion by also referring to the group as a healthy “surrogate family” that can provide patients with a safe “home” in which to fill gaps in emotional learning about self and others and the emotions that normally occur in the process of healthy development. This metaphor is even stronger in the inpatient groups who do live together as a family would. The acceptance and feelings of belonging that accompany the healthy family experience of the group are particularly healing to the Vulnerable Child mode of patients with BPD. The sense of belonging that a group can provide is different from the feelings of connection that take place with a single therapist. Both experiences are important and only GST provides both within the psychotherapy experience. With trained psychotherapists as the “parents”, many patients have their first experience of a healthy and validating family or peer group in the therapy group setting. Patients with BPD in anonymous post-treatment surveys tell us that the group experience was the first place where they felt a sense of belonging and they rank this experience as the most important benefit of the group and healing, above things like learning coping skills.

### *Universality*

The experience of being like others in one’s humanness, and consequently understood and accepted is something that BPD patients have rarely experienced. In post-group surveys another common response is that the group is the first time they have experienced others like them. The experience they report from mixed groups is often that their feelings of being unlike the other members add to their defectiveness and hopelessness. BPD patients frequently tell us that they were labeled “black sheep” or “losers” in their families. Two poignant examples of negative labels from our patients are: one was called “burnt potato chip” as she suffered severe burns in an accident, and the other was nicknamed “vulture” as she was seen as “ugly.” Experiences of acceptance, affection, and care from the group “family” provide important corrective emotional experiences that can be processed in the group resulting in schema change.



Identity is formed in part by internalizing early significant others' views of us. As we know, families of patients who develop BPD often provided very distorted "carnival fun-house" mirrors for patients to view themselves in when they were young children. A therapy group can provide new and more accurate reflections of the patient. The emotional experiences of people with BPD are arguably of a somewhat different character and intensity whether we attribute it to neurobiological sensitivity, emotional dysregulation or insecure attachment. Their intense experiences in interpersonal relationships and their potential for negative distortions of the meaning of others' behavior combine to require a controlled experience with others to facilitate the healing schema change that they need. Such controlled experiences do not occur naturally in adult life or in mixed psychotherapy groups where rejection-sensitive BPD patients may be retraumatized by once again feeling misunderstood and even ostracized due to their extreme behavior. Many patients with BPD over the years told us stories of the groups they were "kicked out of" because they could not stay in the session until it ended or abide by the group's ground-rules. Patients in post-treatment surveys frequently say that the group was the first place that they ever felt understood and accepted and that the experience of being with people perceived as "like them" gave them hope.

### *Instillation of hope*

The instillation of hope is a therapeutic factor of groups that patients with BPD tend to have little of. Having childhoods in which their core emotional needs were not met and where abuse of some kind frequently occurred does little to create hope for the future. Schemas like defectiveness/shame, mistrust/abuse, and failure are not related to hope. Unfortunately, the experiences of patients with BPD within the mental health system have often been demoralizing as well, given the stigma regarding BPD that is so regularly found in most categories of mental health professionals (Treloar, 2009). Many of them tell us some version of having heard that they were "hopeless," people with BPD "never recover," and having their distress and problems dismissed or criticized as "borderline." The group experience offers some hope given that it is designed to help people with this disorder heal and we have promising results from the research studies that have been completed and are ongoing. We tell them about the evidence we have that they can recover and talk about our hope for them. We regularly say to them some version of the following: "We see no reason why this treatment will not help

you if you stick with it and do your part. If we thought that you could not get help here, we would not have accepted you for the group. We believe in your potential to have a better life.” In fact, to share our hope about the recovery of patients with BPD we had wristbands made for BPD Awareness Month (a declaration made by the US House of Representatives in 2008) that read “BPD: Recovery is Real.” We tell patients that they can “borrow some hope” from us if they have little or none, because we have a huge supply. Because these expressions of our feelings are genuine, we find that this has a positive impact on our patients.

### *Interpersonal learning*

Another therapeutic factor of a group is its function as a microcosm of the larger world, providing opportunities to observe others, to get feedback, and to practice skills in a safe environment that are not present in the same way in individual therapy. Groups with therapists as the ever present “good parents” feel safe enough that patients will test interpersonal relationships there. In a group they can begin to risk reaching out to others and expressing their feelings and needs and receive a positive response to their being vulnerable in this way. They can observe that the old defensive coping strategies of detachment or overcompensation do not get responses that meet the person’s needs, but vulnerability does. Other BPD patients are often more tolerant and understanding of the intensely emotional schema-mode experiences that are extremely difficult for people who do not have BPD to understand, and the therapists are present to ensure this.

Multiple opportunities for “in the moment” work occur in the context of group relationships. Another factor not present in individual ST – **the experience of peers** – may contribute to the group’s effectiveness. The presence of peers can provide mutual support and validation, the possibility to safely experiment with emotional expression with people other than one’s therapist, and try new healthy behaviors in the group before taking them into one’s “real life.” The mutual attachment that is possible with peers can heal unsafe attachment representations. The empathic confrontations that group members give each other can often be more easily accepted than those coming from the “parent” therapist as they can feel less threatening and may not trigger defensive coping modes as intensely.

An extension of the therapy group as peer group that frequently occurs is that group members get together for social and supportive activities outside of group sessions. This phenomenon has traditionally been discouraged

in group therapy, but we see it as a potential learning experience. In our experience, when outside group contact is banned, it occurs anyway, but within an unhealthy context of “secrecy” or of doing something “forbidden”; a context that may repeat the abusive relationships of childhood. Group relationships can provide a transitional, relatively healthy adult peer group that many patients with BPD lack. Peer group experiences extend emotional learning experiences from limited reparenting with the therapists to the next developmental stage of learning in the group “family” or peer group. Problems may arise in these interactions, but they can be processed and resolved in the group more easily than when they occur completely outside the therapists’ view. An example would be a situation where most of the group gets together for a party and do not invite one member, but talk about the event in the waiting room before the group session. We cannot tell members who to socialize with, but like the parents of a family we can discuss the problem, point out the negative effects on one of the family. This may lead to the group deciding to invite everyone or an agreement to not discuss publically outings that are selective. Dealing with this issue in group allows a discussion of empathy. We do, however, discourage romantic relationships among group members who do not have strong Healthy Adult modes built. We think that it is too tempting for most patients without a strong identity to fill up their emptiness with a romance.

### *Vicarious learning*

Vicarious learning can feel safer than the more direct learning of individual psychotherapy and can pave the way for allowing the Vulnerable Child to be present. We use vicarious learning to deal with the detachment (Detached Protector) that BPD patients frequently present in early stages of treatment, triggered by defectiveness and abuse/mistrust schemas. When the Detached Protector is taken on directly, detachment usually intensifies, but when patients are merely asked to “be present” and to observe their group, detachment often lessens. Patients can also observe from the safety of their “Safe Place” image. They can observe the way peers are responded to by the therapists in situations of disagreement and conflict even when anger runs high and the Angry Child or Angry Protector modes are present. They also see that peers are not rejected or abandoned for being less than perfect, as the therapists and peers side with them, not the harsh or demanding voice of the Punitive/Demanding Parent mode. They observe that when a Vulnerable Child is present, she/he is nurtured and comforted safely by the therapists

and group. These vicarious learning experiences make it easier for patients to risk being in the Vulnerable Child mode in group, the mode so critical to access for healing. Patients also report that observing and even experiencing the effects of peers' Angry-Impulsive mode behavior or their overcompensating defenses (like Angry Protector or Bully-Attack) has more impact in motivating them to reduce their use of those modes than getting verbal feedback from psychotherapists. In general, these sorts of vicarious learning experiences seem easier for many of these rejection-sensitive patients to take in and make use of than direct therapist feedback to them. Another area of mode work where vicarious learning can be particularly helpful is that with the Punitive Parent. Group members too afraid to confront their still powerful internalized Punitive Parent even symbolically can watch others do it and see that nothing "bad" happens to their peers or therapists. This learning experience leads to being brave enough at the next opportunity to take on their Punitive Parent with the group's support. It also seems easier for patients to see schemas, modes, and cognitive distortions in others, thus providing therapists with examples to remind them of when they fall into the same traps. The use of vicarious learning is further elaborated in Chapter 7.

### *Recapitulation of the family of origin*

**A unique advantage of GST** compared to individual therapy derives from the fact that a psychotherapy group is a closer analogue of the childhood family of origin and the adolescent peer group than an individual psychotherapist can provide. Given that unmet childhood needs are seen as a crucial etiologic factor in BPD and these experiences occur in the family of origin, the recapitulation of that family in the group "family" offers particularly powerful opportunities for corrective emotional experiences – changing schemas and modes at the source. The experience of being part of a group in and of itself can be intensely triggering of modes because implicit memories are pulled for. For many patients this amplified triggering can be helpful in getting through the common maladaptive coping mode of BPD – Detached Protector to reach the Vulnerable Child, the mode that is critical to access in ST.

The limited reparenting of ST is accomplished, in part, by psychotherapists providing patients with the experience of acceptance, validation, and support to help heal their damaged sense of self, self-hatred, and hopelessness. In the group, these experiences are made even more powerful by the addition of a second therapist and the group members. The closer analog

to the family of origin that the group provides may amplify the limited reparenting effects of ST by adding missed socialization experiences with peers and having the “whole family” available. “Siblings” are particularly significant for patients whose biological siblings played key roles in the etiology and/or maintenance of their schemas. In addition, experiences with group “siblings” stimulate different associations and access different implicit memories than therapist “parents” do. The group can provide the healing experience of healthy “siblings.” Issues of sibling rivalry arise naturally in group, and the resulting emotions and schema material can be explored and processed adding opportunities for change. This can be an important therapy moment for patients whose Vulnerable Child feels like she was always left out of the parents’ attention or that her siblings were favored. The therapists’ ability to balance their responses to individual members can provide the Vulnerable Child with the healing experience of having his or her need for healthy attention. Patients can experience that there is “enough for everyone” whether it is love, attention, or having other core needs met. They can experience that they matter in contrast to their childhood experience.

The therapy group as an agent of change is a concept that much has been written about (Yalom & Leszcz, 2005). This aspect of group therapy has been relatively ignored by Cognitive Therapy and Dialectical Behavior Therapy (Bieling, McCabe & Antony, 2009). We emphasize it, and speculate that the effects from being accepted as part of a group that functions like a healthy family is particularly important for patients with BPD and has many positive and healing effects. For example, acceptance and validation coming from peers has a different impact and effects than what therapists can provide. Patients frequently report that positive expressions from peers seem “more believable” or “real” than those from therapists. Despite therapists using the warm, genuine style of ST, we are often perceived by patients as a “professional” who “must say those things” and not a “real human” responding to them naturally and spontaneously. So even though schema therapists are found to score higher than psychodynamic therapists on factors like warmth, genuineness, and other positive qualities of the therapeutic relationship (Spinoven, Giesen-Bloo, van Dyck, Kooiman & Arntz, 2007), patients may still not see us as quite as “real” and “like them” as they perceive fellow group members to be.

The family metaphor can also facilitate the group becoming a healthy replacement for the unavailable or unhealthy family of origin, who are either unable or unwilling to fill the unmet emotional needs of patients. The group can serve that function during its active phase and over time be a

kind of bridge to the world outside of therapy and the patient constructing his/her own family. This bridging effect is very helpful to patients who can be very stuck in the phase of yearning for and hopelessly trying repeatedly to get approval from parents or other family members.

### **Expanded Opportunities for Experiential, Cognitive, and Behavioral Pattern-Breaking Work**

Another source of GST's amplified effectiveness could be that all three categories of ST interventions – experiential, cognitive, and behavioral pattern breaking – are augmented by the group if they are adjusted from an individual focus to one that actively includes the whole group. One such adjustment that cuts across the three categories is what we refer to as “opportunity work.” There are basically two sources of content in psychotherapy: planned work – that comes from the agenda that the patient or therapist has, and opportunity work. This refers to those moments in a session where events occur that can be used as important experiential or cognitive schema challenges. In the GST model for BPD, a second therapist and eight patients multiply the frequency of opportunity work moments. It is possible to return to planned work at a later time, but opportunity moments can be difficult or impossible to manufacture. In GST we seize the opportunity work moment, which is often experiential. Examples of such moments and the other ways in which the group can amplify the effect of experiential, cognitive and behavioral interventions are described in the next sections.

#### *Experiential interventions*

An advantage of doing emotion focused work in a group is that affect can be amplified by the mere presence of more people in the therapy space, thus assisting the goal of eliciting the implicit knowledge and associational memories that accompany affect. This emotional material can then be explored to learn more about the memories and root experiences of a patient's schema modes, and will ultimately assist in trauma processing work that includes cognitive restructuring/rescripting of the meaning of these memories and imagery rescripting. Many opportunities for such emotional level mode change occur in GST where affect is aroused and cognitive processing is facilitated by therapists and other group members. Often just the experience of doing imagery, even the “safe place” image, as a group adds enough energy to create a chink in the armor of the Detached Protector.

Group members also provide extra characters for role-plays and other experiential work that can increase the salience of these techniques. For mode role-plays we use other patients as the various modes instead of empty chairs. We have found that patients are more willing to participate when the exercise seems more salient and real and that there are significant vicarious learning opportunities to be tapped when patients watch these role-plays. When group members play dysfunctional “parent” modes they are likely to play aspects of their own parent mode, lending added authenticity and possibly vicarious learning for themselves from the awareness gained of the effect of such a parent mode. When doing role-plays, if one patient plays her/his Healthy Adult mode and another the Detached Protector, the Detached Protector can be very effective as a “devil’s advocate” as they know all too well the responses likely to be given in that mode and compelling counter arguments to make. Sometimes just observing other group members doing role-play work triggers emotional responses that reach the Vulnerable Child.

The group can be a safe place for experiential work with the Angry Child mode. The collective physical strength and emotional presence of a number of people (peers and therapists) can provide feelings of containment that are reassuring for the patient doing the anger work. Venting anger can feel safer in the larger physical space that a group requires. Role-play work is particularly useful here as there are numerous potential “actors” to call upon. To help vent the underlying rage of the child whose needs were not met, a peer can play the Punitive or Demanding Parent with one of the therapists playing the supportive Good Parent Defender. Assertiveness can be practiced in group as the Angry Child moves on to develop Healthy Adult skills for getting needs met. Group experiential exercises can be used to access and provide outlets for the Angry Child mode of more repressed patients. Two examples are “tug of war” games using a towel with patients or patient and therapist at opposite ends, and contests in which a pair stands back to back and tries to push each other across the room. With therapists monitoring, these are safe exercises to access anger in a setting where it can be worked with. Patients with BPD are usually very frightened of their own anger and may only experience it when it breaks through Detached Protector mode in a maladaptive form such as Angry or Impulsive Child modes, Angry Protector or Bully-Attack coping modes. They have also usually experienced the angry voice of their PP after such an expression of anger. Patients sometimes run out of group sessions to avoid such angry expressions. In group play with anger they have the opportunity to allow anger to be accessed and to blend it with play in the rough and tumble

version that is the way all mammals learn to deal with anger and aggression within the social group context (Lockwood & Shaw, 2011).

Banishing the Punitive (or Demanding) Parent is a goal of ST that is significantly augmented in a group. An entire group of strong adult patients can more powerfully challenge and banish the Punitive Parent than a patient who feels like a small child and their individual therapist are able to. Imagery work in which the group and co-therapists become one's "protective army" can be developed, practiced, and used to continue individual Punitive Parent work. Patients can concretize their army with drawings that they place in strategic locations to remind them of the group experience.

Elements of play are easily introduced in the group setting where there are both parents and playmates to play with. As the group bonds and forms the multiple overlapping attachments of a working psychotherapy group, the supportive atmosphere that is generated along with the sharing of experiences provides a comfortable mutuality that lends itself to play. Experiencing the playful side of therapists may have a disinhibiting effect for patients whose dysfunctional parent mode voices tell them it is "silly" or "unacceptable" to play.

### *Cognitive interventions*

GST can also augment the cognitive work of ST in a number of ways. Information about what is "normal," reality testing of the "truth" of family of origin beliefs (e.g., it is weak to express feelings) and the effects of unmet childhood needs can be discussed in group with the addition of a larger pool of information on these topics. Group members sharing their experiences can provide normalizing effects similar to the effects of therapist selective self-disclosure. One patient may put into words an experience that another can recognize but previously had no words to express. Sometimes information from professionals seems ideal or not part of the world the patient lives in, whereas peers are seen as more realistic sources of this kind of information. Work to understand and recognize modes is facilitated by group as patients can more easily see and identify these shifts in others. The same is true for cognitive distortions. The same patient who is unaware of dichotomous thinking in herself may be the first to yell out "that's all or none thinking" when a peer is distorting.

### *Behavioral pattern breaking*

As described in the section above on "Interpersonal learning," the group as a microcosm of the larger world outside of therapy is an excellent place to



practice and get feedback on changes in behavior. The group can provide a naturalistic “laboratory” for missed attachment experiences where maladaptive schemas and modes can change with limited reparenting. Mode management strategies, establishing boundaries, and assertively asking for needs to be responded to can all be practiced with peers. Sometimes this feels easier with peers than with one’s therapist as it feels like there is potentially too much to lose with a therapist, particularly a sole individual therapist.

**We conceptualize psychotherapy for BPD as a broad process of facilitating emotional development to healthy adulthood** by correcting the maladaptive schema modes that resulted from critical needs not being met in childhood and adolescence. We speculate that each of these stages is optimally impacted by a different modality of ST. The attachment needs of infants and young children may be optimally met in an individual psychotherapy relationship that can provide individual limited reparenting that offers the emotional experiences of safety, validation, comfort, and joy that were not available in the patient’s early environment. The next stages of healthy development, late childhood and adolescence, where the separation and individuation tasks of identity formation are critical, and adulthood, where healthy autonomy and more equal relationships are the focus, require learning experiences that go beyond relationships with an individual therapist “parent” to include “siblings” and a peer group. BPD patients, who are dealing at first with the issues of early childhood, need initial secure attachment with the therapist(s), a safe “family” group, an adolescent peer group, and finally an adult social group. The ST group described here has been designed to provide a range of healing interactions by providing individual limited reparenting with the therapist and the important later developmental interactions with a group “family” and peers.

### Example

Terry’s group experience demonstrates some of the healing effects specific to group. Terry came to her first inpatient ST group with a hood pulled down to obscure most of her face and described herself as “evil.” After some time in the group, she offered that she had decided that she was “not entirely evil” because her peers did not treat her as if she was an undesirable and unworthy person. Terry grew up in a rural

area on a large farm and was kept socially isolated with her abusive biological father who was also her biological grandfather. Her mother's response to her was one of discomfort and distress, as Terry reminded her of being raped by her own father. Terry's father/grandfather reacted in a similar way because to him she represented the reason he had spent time in jail. Terry internalized their reactions as her identity and explained their lack of love and mistreatment as due to her being "bad and evil." The therapy group for her was the first exposure to accepting peers. She had also been made fun of, bullied, and rejected by schoolmates in her small home town who knew her family story. Terry had seen individual psychotherapists, but their acceptance had much less impact than that of seven peers. She felt, for the first time, that she was "one of them" and belonged somewhere. The group experience was a real breakthrough for Terry's psychotherapeutic treatment. After discharge and a period of outpatient treatment, Terry went on to successfully complete a college degree in social work and is working in mental health.

In conclusion, we explain the large treatment effects found for GST in terms of the catalyzing and amplifying interactions between ST interventions and the therapeutic factors of therapy groups. GST may provide the best of both worlds of psychotherapy for BPD patients as it combines opportunities to experience limited reparenting from psychotherapists as well as missed socialization experiences with group member "siblings." The group is a closer analogue to the family of origin for corrective emotional experiences to take place in. Group can be a safe "family experience" in which the gaps in emotional learning about self and others and emotional experience that occur normally in the process of healthy development can be filled in. The therapeutic factors groups provide directly impact the main maladaptive schemas of BPD. GST provides additional "opportunity work" in all three areas of intervention: experiential, cognitive, and behavioral pattern-breaking.

Many of the group challenges with BPD patients are related to the abandonment or rejection sensitivity of this group and their propensity to distort feedback they are given along schema lines. The fact that there are more people involved translates into increased possibilities for immediate triggering effects of peers, intense "sibling" rivalry, and schema chemistry. Group

members can have very variable experiences to the same situation or even therapist initiated exercise in the group depending upon their interpersonal histories and particular mistrust–abuse issues. One example of this is whether the group adds or diminishes anxiety during the bonding phase. Patients who were abused as children sometimes feel safer in a group where there are peer “witnesses.” Others who suffered bullying from peers or siblings may experience a more negative effect in group. Whichever occurs, it can be worked with as long as the therapist recognizes the different modes that occur. These are times at which the skills of the group psychotherapist are critical.

Groups require stability, consistency, flexibility, creativity, a loud or soft voice depending upon the task, a well-developed sense of fairness, a good deal of freedom from schema issues, and a good support or supervisory group. We have found that the added challenges for the therapists in GST that are not present in individual therapy can be handled by the co-therapist model we developed for BPD patients. When the challenges listed are maneuvered successfully they provide important additional emotional learning opportunities. GST is also an exciting and dynamic experience for psychotherapists, in which they can learn much about their own schemas and modes. In addition you will seldom, if ever, be bored.

# The Therapist Role: Limited Reparenting Broadened to a Family

J. M. Farrell and I. A. Shaw

A group presents therapists with both opportunities and challenges not present in individual Schema Therapy (ST). This chapter describes the group therapist behaviors that are necessary to develop and maintain the frame needed to successfully conduct ST in a group for Borderline Personality Disorder (BPD) patients. This includes the behaviors required to provide the limited reparenting therapy relationship of ST for a group, build a healthy working group “family,” and work together with a therapist partner to manage the expanded tasks of the GST model. Integral to the GST model is the therapist focus on using the tremendous value of the group by facilitating its therapeutic factors. The common challenges that arise in a BPD group are also discussed with suggestions on how to handle them. A summary of GST therapist “tips” is provided in REF 4 (Patient Workbook).

## General Therapist Behaviors

It is imperative in group therapy for BPD patients that the therapists model a strong, consistent, affirming, and supportive presence for each patient and the strength to reparent the group. We learned this the hard way with our very first group, which we fondly refer to as the “group from Hell.” It was 1987 and new approaches for BPD, like DBT, were not in print as we were developing the GST model. Experts were suggesting a poor prognosis for this group of patients (e.g., Stone, Hurt & Stone, 1987). Most would not have considered including a single BPD patient in a group, let alone attempt an all BPD group. We had no way of knowing how our approach to

remediating early emotional learning deficits and challenging maladaptive schemas in BPD patients would work in the group format.

The patients picked up our uncertainty. They resisted and protested many of the experiential interventions that we tried and at that time we had no data to support the idea that they would help. When we worked to increase their emotional awareness, they complained that we were “making them feel worse.” We talked about emotional thawing and they asked “Why in the world” we would want them to do that. We had not yet discovered that the intensity of the pain they feel is paralleled by equally intense experiences of joy and love. It was difficult for us to give them hope when the published treatment literature described a poor prognosis. As we developed the model and the outcome measures we used demonstrated large improvements, we were able to project the strong, confident parents BPD patients need and our “group from Hell” was never repeated. We learned a lot from our early patients and even that first group got better eventually. We also learned when to step back in the autonomy stage of treatment when they have a Healthy Adult growing in strength who now needs to feel competent in the group as practice for life outside therapy.

### **Limited Reparenting for Individual and Group Schema Therapy**

Limited reparenting is at the heart of ST, especially with BPD patients. This approach involves a broad range of capacities on the therapist's part ranging from comforting and validation to empathic confrontation. Both patients and therapists report that they see limited reparenting (along with the mode model) as one of the most powerful aspects of ST. Young et al. (2003) describes limited reparenting as meeting the core needs of the patient which were not met in childhood, within appropriate professional boundaries. This approach to needs is in sharp contrast to cognitive behavioral therapy (CBT) and most approaches to psychodynamic psychotherapy. These therapies, and most others (e.g., DBT), focus too early on patients meeting their own needs. ST recognizes the weak Healthy Adult mode that patients with BPD begin therapy with and takes the position that the gap in early emotional learning which results from core childhood needs not being met can more effectively be filled through an initial phase in which therapists meet needs directly, providing these missing new positive experiences. The new experiences, interactions and implicit attitudes that make up the process of meeting core emotional needs become the building blocks for the Healthy

Adult mode. In group, needs are met by both the therapist and the group. GST offers additional opportunities for emotional learning and socialization from these interactions with “sibling” group members and from the experience of belonging to a group “family.”

The behaviors of the schema therapist can be summed up as “doing what a good parent would.” Early in treatment, strong parenting is needed as BPD patients are frequently in child modes and have an underdeveloped Healthy Adult mode. Later on there is more Healthy Adult mode presence and the therapists’ role changes to being parents of adolescents and then eventually adults. In this later phase, patients still need the therapists to maintain connection, but are able to do some parenting of themselves and each other. The language, sophistication, and the use of specific ST techniques must be adapted to the developmental level, comorbid disorders, and psychological health of the group members (i.e., some techniques and terminology that may be helpful with BPD patients may not be acceptable to Narcissistic Personality Disorder patients). In BPD groups, when working on the Vulnerable Child mode, we sound like parents talking to a young frightened child. When confronted with Maladaptive Coping modes we can become almost as firm as a drill sergeant (while at the same time not losing touch with letting the patient know that we empathize with the feelings and needs underneath).

### **How Many Therapists Does it Take to Parent a BPD Group?**

Part of the foundation of ST is secure attachment, and achieving the reliable connection this requires can be challenging in the beginning of GST. A basic difficulty for group therapists is finding a way to stay connected with eight or more patients while doing the other change-focused work of a given treatment model. In a group, the task becomes to reparent a large family rather than the only child of individual ST. The model we developed for BPD solves this by having two therapists. The changes that ST groups require, including the number of therapists, is a function of the developmental level of the group members. With BPD patients, we are dealing with people stuck at childhood developmental levels with early emotional learning deficits (e.g., lack of secure attachment, deficits in emotional awareness). Just as it would be difficult for one parent to manage eight very young children without the assistance of another adult, dealing with eight BPD patients in a variety of child modes can be overwhelming for one therapist.

*Working in a co-therapist team*

A co-therapist team that has learned to work well together benefits the group and the therapists. We use the term co-therapist to refer to one of two equal therapists. Having two therapists allows for ongoing awareness of both the group and the individuals in it. Ideally, the switch from individual to group ST allows us to use the potential of the group, but not lose the benefits of individual therapy. We want to be able to briefly focus the group for work with a specific individual and then broaden the focus to include all members and make it relevant for them even if they are not directly involved. Otherwise you are just doing individual therapy with a group watching and it will dilute the individual work and miss unique group opportunities to augment and catalyze ST. A skilled group schema therapist can be likened to an expert orchestra conductor who can creatively blend each unique voice into a coherent whole that is greater than the sum of its parts. This requires always being alert for a member who is “out of tune.” Therapists must act quickly, during the conflict stage of group in particular, to redirect or focus the group or limit a patient before the disruption or escalation gets out of hand. A co-therapist team allows GST to truly be *group* therapy, in contrast to most CBT groups (Bieling, McCabe & Antony, 2009). Unlike psychodynamic approaches to group, there is active therapist involvement and direction rather than the passive facilitation, which allows more conflict and emotional intensity than BPD patients can tolerate.

Being present in a group session without being included in any meaningful way is not something most patients with BPD can tolerate for any length of time when emotional level work is being done. Taking into account the early level that these patients can be at developmentally in terms of emotional awareness and attachment, and how young their Vulnerable Child mode can be, it is understandable that they can feel lost and scared, even abandoned, if they feel no tangible therapist connection for any significant amount of time. To make GST work for this population, someone must actively maintain the connection with them. That is where having two therapists becomes important. Eye contact and nonverbal connections are particularly important for very young Vulnerable Children. Maintaining nonverbal connection with the rest of the group, when a verbal connection is being made with an individual or part of the group, is an important strategy of GST. To engage the therapeutic power of the group patients need to have a role that is more than being an observer (e.g., be involved as a cheering section for an anger exercise).

When one therapist is focused on an individual patient, it is important for the other therapist to be vigilant to the rest of the group and not be too drawn into the individual focus of his/her partner. We have observed in training role-plays that a therapist's focus automatically goes to the "action" – the individual work being conducted. Since most of us train first as individual therapists we are conditioned to attend to the individual work, and even to view this as the "important" work. In group it is *equally important* to maintain connection with and focus on the group. Group therapists must train themselves to this new definition of the work and be able to alternate individual and group leads with their co-therapist partner. It is important to avoid both therapists focusing attention on the same patient for any length of time. When one co-therapist is focused on a particular individual, the other pays attention to the affect and modes of the rest of the group and looks for opportunities to pull them in. For example, if a patient is talking about feeling empty, the co-therapist might turn to the group to ask if anyone else is feeling that way and what need are they aware of, or if others have ideas about what helps them when they feel empty. As the second therapist tracks the rest of the group, he/she will also be observant as to what is happening with the patient of focus and will not start other interactions that will be distracting until it is an appropriate time to pull the group in. The non-leading therapist needs to support their co-therapist's intervention but not interrupt it or take it in a different direction unless it is clear that the lead therapist is floundering or has signaled for help. Establishing signals that indicate when help is needed is another important part of working as a co-therapist team. A therapist may need help because his/her own schemas are triggered, because the other therapist has a closer relationship with the focus patient in Vulnerable Child mode, or because they don't know what to do in a situation. It works best to choose a signal that both can recognize and which is not part of your frequent nonverbal behavior. We have worked together so long that a specific signal is often not necessary, but we have a range of them: lifted eyebrow, wide eyes open glance, and others. An excellent experiential exercise for therapist connection is presented in REF 6 (Perris, 2009)

There are a number of occasions when the therapist who is not currently leading will deliberately stop the main action. One is when the rest of the group seems disconnected or lost due to not having enough content information about the working patient to understand what is happening. This experience can trigger lack of belonging or even abandonment with a flip into the Vulnerable Child mode or a coping mode like Detached



Protector . When this happens in a number of patients, stopping the action briefly to bring everyone together has schema healing effects for all. Another occasion is when the tension has become too high for the other members to stay present and not detach. The second therapist can ask everyone to take a deep breath followed by a brief mode check in. Situations where the individual focus goes on too long, the rest of the group seems either bored or neglected, and there has not been a naturally occurring opportunity for the second therapist to bring them in, is a time for him/her to stop the action to reconnect the group. Another time to interrupt is when you observe that the rest of the group is having a reaction that needs to be acknowledged. It is important for one of the therapists to intervene quickly in response to shifts in the group that portend the eruption of a reaction not helpful to the current work of the group. Active attention to the group is important to be able to stay cognizant of unmet needs that can grow to eruptive proportions. We were reminded of this recently in a role-play group with therapists in training when we observed both therapists completely miss important communications from patients that could have prevented an outbreak of chaos.

### Example

A situation occurred doing some Punitive Parent mode experiential work where half of the group wanted to beat up the PPM effigy they had constructed and half were in Vulnerable Child mode, feeling very fearful of the Punitive Parent mode. As an observer, I heard the most distressed (and also most disruptive) patient say “Why don’t we make a Good Parent effigy to protect us?” Neither therapist seemed to notice this and both went on to work with the group that wanted to be aggressive. As they did this, the fearful patients covered their ears, rocked, moaned, and finally screamed, disrupting the entire group and bringing the action with the Punitive Parent mode to a standstill. At this point the therapists could not ignore them. As they tried to calm their fears, the group angry at the Punitive Parent mode became critical of the fearful ones calling them “babies”, attention seekers, etc. The rest of the exercise was spent trying to calm all of them down. We discussed with those playing patients what they thought would have happened if one of the therapists had heard the suggestion and

acted on it while the other left with the Punitive Parent mode work. They answered that they thought it would have worked. The trainee therapists said that they did not know what to do when faced with several frightened patients and others who wanted anger release and venting, and they had not noticed their patient's suggestion. Our response was that the group told them what would work and that the group is often helpful in that way. As therapists we just need to hear them.

This reminded us of how important it can be to hear the suggestions of the group and how not hearing them can lead to the need being expressed in a louder more disruptive way that will be more difficult and less productive to deal with. It also works to ask the group to help solve a problem. However, you have to be ready to jump in if they cannot come up with anything. In general, having some patients take action to meet one need and the rest a different action to meet their different need is usually a winning intervention. It gives patients the experience of their needs being responded to as important and legitimate and the awareness that they do not have to be sacrificed as they were in childhood. Two therapists, with one always attending to the group, are much more likely to pick up on the group's needs being expressed or suggestions being made. They are also less likely to let silences occur that are too long. We tell therapists in training that in the early life of a BPD group, what pops up after too long a silence is not usually anything that you will want. It is usually some manifestation of a coping mode, frequently an angry one that may exceed the group's ability to tolerate conflict in early sessions. Two therapists can also better meet the cumulative needs of a group of BPD patients, who can be quite needy at times, without becoming overwhelmed or "burned out." Two therapists with different styles and temperaments provide added opportunities for all patients to have someone who they can feel connected to. We are able to play different roles in experiential work. One of us can be supportive of a patient's feelings while the other can set needed limits on behavior. If necessary, we can even briefly step out of the session when a patient in Angry Child mode who needs to vent but who is scaring those in Vulnerable Child mode. GST can, at times, be more intensely schema-triggering for therapists than individual ST is. On these occasions, either in the session or later in

peer supervision, the co-therapist partner's observations and support are very helpful.

At times, practical considerations require that one therapist manage an all BPD group. Although quite difficult, we see the one-therapist BPD group as a better option than not being able to offer a group at all. A single therapist group will require more structure; the structure replacing the second therapist and serving to hold the environment constant and provide adequate safety. One suggestion for settings with multiple therapists who run solo groups is that they replace two of their solo groups with one group that has both of them as leaders. We faced this problem in our inpatient groups after losing one member of the therapist team. Since this occurred when we were collecting pilot data on the effectiveness of inpatient GST, we had measures of BPD symptoms and global severity of psychiatric symptoms that allowed us to compare a group with two therapists ( $N = 42$ ) to a group with one therapist ( $N = 36$ ). We found that, although there were still reductions in symptoms that were statistically significant in both groups, the treatment effect size in the single therapist group decreased significantly. The effect size still matched or exceeded that of other approaches to BPD treatment, but did not match the positive effects of the two-therapist GST. These results are described in Reiss, Lieb, Arntz, Shaw & Farrell (in press). Since it was a pilot study, we can only speculate on the role that the variable of therapist number had on the result. However, that was the only thing that was different about the two studies. The groups were conducted at the same hospital, on the same unit, with the same inclusion criteria, and three of the four same therapists. Groups with patients who have a more developed Healthy Adult mode, less severe impairment, and who are at a more advanced developmental level may be adequately led by one therapist. We do not yet have outcome studies that test this speculation. With higher functioning patients, the peer group's role can be a more active one, conflict can be tolerated and resolved at times by the group members, and the focus of the work shifts from attachment to identity and autonomy.

### **Therapist Behaviors to Foster Connection**

Many of the therapist behaviors of GST have the goal of facilitating the therapeutic factors of groups in the service of the ST goals of changing modes and meeting core needs. Some therapeutic factors of group facilitate ST

mode change directly (e.g., recapitulation of the family of origin, vicarious learning, and interpersonal learning) and some set the stage for the group to be an agent of change (e.g., cohesiveness). Connection is one of the core needs that fits in the latter category.

As in individual ST, the initial goal for the therapists is to establish an active, supportive, and genuine connection with each patient. Similarly, it is important for both therapists to maintain a bond with each patient through each session. From this foundation, the therapist can form bonds collectively with the group. In group, therapists must also facilitate members connecting and bonding with each other, the other therapist, and the group as a whole. The family metaphor first discussed in Chapter 3 is the way we refer to the group as a whole to make it tangible and real for patients. (See Chapter 10 for a discussion about managing the bond patients have with their individual therapist.) We think that patients in group can develop individual bonds with both therapists and that the additional interactions and bonds that occur with group members add to the experiences of belonging and connection. These attachments are healing for the Vulnerable Child mode of BPD patients. We are constantly moving from individual to group and from group to individuals, balancing our attention to both and weaving the group and individual work together.

### *Strong connection is critical*

With BPD patients, one of the first barriers therapists will encounter is the mistrust/abuse schema. This will be familiar to therapists experienced in individual ST with BPD patients. In the group, mistrust can be amplified and its energy strongly felt in early group sessions. The group therapist must be active in facilitating early connections with individual patients and the group and modeling a strong connection with the co-therapist. Connection in the group can also be amplified and its strength felt. The therapist is the parent who accepts and values each patient for being her or himself, wants to know them and understand their needs and help them establish relationships among the siblings of the group family. We make it very clear to patients at every session that we are glad to see them, they are an important part of the group, and they are missed if not present. Our connection with them is what aids retention and fosters good attendance. Our ground rules require patients to let us know when they are unable to attend a session and convey the expectation that they will only miss a group for very serious

reasons. If they miss a group and have not called in, we call them to check in. Even if they have called in, we contact them after the group to convey that they were missed and to make sure they are not in crisis. We have found that maintaining such active connections with patients is a major mechanism for keeping BPD patients present in group sessions, both physically and emotionally, and free from detachment.

Because a psychotherapy group is a closer analogue to the childhood family of origin or adolescent peer group than an individual psychotherapist can provide, schema mode triggering and healing opportunities are amplified. Being in a group can be strongly triggering of the abandonment schema which can set off a coping mode such as Detached Protector. BPD patients report “feeling abandoned” at times in group sessions when the focus is not on them and coping by “spacing out,” or even leaving the group room. As we were developing this group model, we kept in mind our experience in mixed diagnosis groups of the patient with BPD running out in distress that seemed to have no apparent trigger. In discussing this behavior with patients, we came to understand that it was painful disconnection they were responding to. This is one of the reasons why we emphasize so much that it is critical to develop a strong connection with each patient in the group and have a way to maintain this connection during the group sessions in order to keep all patients present physically and emotionally.

In individual therapy our focus is on our patient at all times. In a group our focus, by necessity, travels as the group proceeds. It is very important to always be aware of all group members. This is especially important for patients with BPD whose basic needs were ignored and who often describe their experience with others as “being invisible.” Maintaining good eye contact and directing an accepting warm gaze at patients is one important tool to use to maintain connections with all members at times when verbal behavior is focused on another patient. Making eye contact communicates to each patient that we literally see them. Lockwood (2008) asserts that this visual connection between therapist and patient is crucial to secure attachment, is the most powerful form of non-verbal communication, and is supported by the findings of interpersonal neurobiology research. We notice in reviewing our group videotapes that we make noticeable efforts to keep rotating eye contact, stopping briefly at each patient so that the connection between us is acknowledged. Patients have often told us that just knowing that we were looking around made them feel secure and as if they “mattered” even when verbal attention was on someone else.

In a group we have the practical dilemma of “seeing all” when we are doing work that focuses for at least a short period of time on one patient. As stated earlier, one of the therapists always has the task of attending to and maintaining the connection to the group as whole and all individual members. This therapist task cannot be accomplished by simply scanning the group. It requires making distinct, warm eye contact or other nonverbal behavior that makes an emotional connection with each patient. Examples of this include: looking around the group meaningfully and nodding just after directing a verbalization at an individual, a nod or raised eyebrow to a patient when a peer is relating an issue or reaction that we know that other patient shares or can relate to, a thumbs up gesture with a nod to the work being done, a smile or sympathetic look that communicates shared pleasure at the progress being made in the work going on or shared compassion at the other’s struggle. All of these therapist behaviors are ways to convey to patients their inclusion in the group’s work. Patients will not always look back at us, but it is possible to look in a way that you know they see you looking. All of these nonverbal cues are easily picked up and appreciated by patients with BPD who have very sensitive radar for other’s reactions. We have been told many times by patients that even though they did not feel able at the time to look back, they were aware of one of us always seeing them and it was reassuring. Sometimes they even tell us how many times we looked at them. It is also important to remember that we know from research that BPD patients have no particular difficulty reading emotional expressions in general, but tend to misinterpret “neutral” expressions as angry. We allow our faces to genuinely reflect “good parent” emotions as we work with the group. This means inhibiting our own schema-related impatience or negative feelings toward the group or a patient.

The group therapist uses the modulation of his/her voice as the baton of an orchestra conductor. When a patient is verbally breaking ground rules it is necessary to talk over what they are saying with “stop” of increasing volume, accompanied at times by a raised hand toward them and getting out of your seat and moving toward them if necessary, always making direct eye contact. If they start to leave, you must counter quickly with, “Please stay, you are important to us, we want to hear how you feel (followed shortly by), but the way you are expressing it right now is an attack on your peer and violates our ground rules.” We have also noticed that our physical gestures of inclusion such as open arms and leaning forward are larger and even somewhat exaggerated in a group. We amplify our nonverbal protective

gestures toward group members. For example, we might separate angry venting members from those in Vulnerable Child modes by literally standing between them or leaning forward with arms outstretched protectively in front of patients who are being addressed aggressively. The other therapist responds to the mode of the aggressive patient verbally. We move around more than is necessary in individual psychotherapy in order to be close enough to a patient who is distressed or to set up experiential work. We see such adaptations in therapist style as appropriate efforts to match the larger stage that groups present.

Touch is another nonverbal behavior to use for connection. This is a topic of some controversy in psychotherapy due to the ethical violations of a small number of psychotherapists. Our position is that touch should only be used after explicit permission has been granted and should always be limited to touch that cannot be misinterpreted as intimate or sexual. To us, this means a pat on the shoulder or back (never on the knee or thigh, although a pointed finger touch to the knee may be permissible to get attention), holding a patient's hand, an arm around a crying patient, sitting close by and allowing the patient to lean on you sideways and non-intimate hugs. We realize that different cross-cultural norms exist regarding physical contact and so suggest keeping in mind two issues: only do things that you feel comfortable with in terms of your personal and country norms so that the expression can be genuine, and pay attention to the patient's response, as even when general permission has been given it could change depending upon the mode present. (We were surprised recently to discover that American style hugs, which are so common and considered non-intimate in the US, are considered much more "intimate" in the Netherlands than the "three kisses on the cheeks" greeting of the Dutch. While we are very comfortable hugging patients, we would not be comfortable with kisses of any kind.)

Cohesiveness and belonging in the group can have huge effects on healing BPD schemas as seen in Table 3.1. To facilitate cohesiveness and underline belonging, we make statements like "All of you are welcome here, all of you have a place in this group." Additional comments include: "You are important to the group, you make valuable contributions for the group family, there will always be a place for you here, and we care about all of you." These sorts of comments are the kinds of "good parent" statements that we include in the scripts that we use for the Safe place imagery that we do at the beginning and end of groups. Hearing words that clash with schemas can be easier, especially at first, for group members to take in with their eyes closed or head down, than when making eye contact with

the therapist. In later sessions, maintaining eye contact while listening to positive feedback and expressions of caring and belonging is emphasized.

One example of an exercise where the issue of maintaining eye contact occurs is the “Identity Bracelet.” This exercise is done near the end of year one and a full description of it is included in Chapter 8. Briefly, each patient is given a bead from everyone in the group which is accompanied by a statement about a positive personal characteristic or strength the giver has observed. We ask the patient receiving a bead to make eye contact with the one giving it. This is often difficult for patients, but it offers significant healing for the Vulnerable Child mode who did not experience this kind of acknowledgement and validation as a child.

### **Therapist Behaviors to Build the Group Family**

As described in Chapter 3, we use the metaphor of the healthy family for the group. With direction from the therapists that matches the group needs, the multiple connections and variety of socialization opportunities with “siblings” which are possible in a group can provide a safe and supportive family. A task of the therapists is to support this metaphor and use “family language” to further group interconnections. We have found that this label can be called upon at times of group conflict or when there is an atmosphere of animosity in the group for whatever reason. Examples of using family language are: “We need to solve this and restore our supportive healthy family atmosphere,” “We are a family, everyone here is valued and no one will be kicked out or have their needs sacrificed,” and “This is a healthy family and we do not treat each other in an unkind or disrespectful way here.” We have found such interventions to be very effective as patients with BPD have a strong need at their core to be part of such a family.

#### *Universality – point out commonalities among patients*

Another way to facilitate patient bonds and cohesiveness is to point out what they share, for example, similarities in the problems that bring them to therapy and early childhood experiences. This fosters universality, one of the therapeutic factors of groups. We constantly point out similarities in group members’ experiences as well as differences. Pointing out similarities is particularly important given the pervasiveness of defectiveness and social isolation/alienation schemas in BPD. An early exercise that we use in the



psychoeducation part of group involves patients identifying in a homework form the symptoms of BPD that they experience. We go over this form in the following session, asking for a show of hands as to how many experience each of the symptoms. Typically there is high endorsement of many of the symptoms. We make sure that the patients look around to see how many others share the experiences that they thought were unique to them and often feel ashamed of. This can be an important healing experience for those who have been in other groups with people who did not share their difficulties and in which they felt isolated and odd. We use the “show of hands” method for many shared issues to make sure that patients take note of similarities as well as differences. We see this as part of the guidance of limited reparenting. Another example is to point out the shared emotional experiences underlying different life experiences. For example we might say “Isn’t it interesting how even with very different family styles, neither met your need for security.” Discussing the similar damaging effects of sexual, physical, and emotional abuse is another important universality topic that can lead to schema healing. We tell patients that blaming themselves for the abuse is a common response of children and describe the damage abuse does to their sense of self and identity. We link their defectiveness/shame schema and sense of being “bad” or having something “bad inside” to the abuse and work to help them separate it from their sense of self. We work to remove the label “bad” from the Vulnerable Child mode. Simply stated, we tell them that children who are abused think they are bad, but it is not they who are bad, it is the abuser who is bad. We discuss the other ways that patients with BPD feel different from others and, when appropriate, reframe them in a more neutral way or explain them as reactions to childhood needs not being met. For example, their almost universal sensitivity to abandonment is presented as a normal sequel to childhood needs for safety, security and predictability not being met. Often a patient in group will ask “Am I wrong?” when we discuss the effects of their early environments. The answer to that question includes a statement of validation that we repeat frequently, “Anyone with your temperament (which you could not control being born with) who experienced what you did growing up would have the same issue.” Almost always we can follow this with pointing out that other group members share these feelings.

The experience of being in a group with others who are “like them,” in and of itself, is powerfully healing for their Vulnerable Child mode and begins the work of building the Healthy Adult mode and a more positive identity. In anonymous evaluations after participating in GST, patients listed “being

with people like me for the first time” as one of the most helpful aspects of the group experience. It is just as important in limited reparenting for therapists to point out that being “different” from your group siblings does not mean that you are wrong or bad. The group members come to understand that differences add to and enrich the family as long as they do not hurt others. The group, as a whole, is invariably more accepting of differences than patients expect. People with personality disorders, particularly BPD, often had the experience growing up of being different from their other family members and being punished for it. Even in instances in which patients are different in ways most would evaluate as positive, like not getting drunk, abusing drugs, or fighting physically like their family members, the patients feel “wrong” because they were not like the family.

### Example

A patient, who is the daughter in a family of lawyers with two siblings who are physicians, grew up feeling that being different made her wrong, not just unique. Sue was seen as “different” from her family due to her interests in art and animal care and they perceived her to be over-emotional and “too sensitive.” She completed medical school, but could not fit into life as a physician. In schema therapy she eventually came to understand that she was just different not wrong or bad. Peers in the group liked her differences from her family. She came to value them also, after many years of self-injury as punishment for being different and long periods of psychiatric hospitalizations.

We try to support, acknowledge and celebrate any differences in the group that are not harmful to the patient. This approach is an example of some of the reparenting that is needed with respect to identity for patients with BPD. Appreciating what is different and unique about each group member helps to build a loving and accepting group family.

### **Therapist Behaviors to Establish and Maintain Safety**

A group environment of safety is essential to developing the empathic, nonjudgmental, caring and gentle group culture which can augment the

work of ST. Although we think that all groups need safety, a somewhat different culture may be appropriate for a group with different typical modes such as groups with antisocial or psychopathic patients. A BPD group without strong safety measures will be a group of patients in coping modes; most frequently Detached Protector mode, including its extreme form of dissociation. This makes it very important for the group therapist to provide strong leadership in establishing and maintaining a safe environment. The foundation that we use for safety is built on the patients' agreement to follow a set of ground rules. The ground rules we use are provided in REF 1. Here we discuss therapist behaviors related to safety and in Chapter 5 the more procedural aspects when a patient must temporarily leave the group. All patients must commit to following the ground rules as a condition of joining the group, but therapists must be ready to remind patients of them if they are broken and to insist that they be followed. The therapists' guidance and limit setting regarding ground rules is most critical in early sessions when the group itself is not yet at a stage in which it can enforce group norms. In early sessions our reminders are supportive and firm, yet caring, combined with acknowledging the underlying need the patient is trying to get met. This usually leads to the patient stopping the problem behavior. Later on in the group, after a number of reminders, or if the behavior is disruptive to the group, we might ask a patient to go to the safety area that is established with pillows and blankets in a corner of the group space, or as last resort to leave the group temporarily if they cannot get the problem behavior under control. It is important to take this stand if the problem behavior has significant negative effects on the group or other patients. Our actions are different depending upon whether we believe that the patient could control the action or not. Patients sometimes say that they fear feeling as it might escalate and they would not be able to control it. We reassure them that we will help them with limits as needed. When we do not think this is yet under the patient's control, we are more active in going with them (if we have two therapists) to help to de-escalate. Even then, we will not stay out of the group for long as we do not want to reinforce the behavior. We may step out to arrange for a receptionist to keep an eye on the patient and call for help from clinical staff if needed. Aggression, physical or verbal (e.g., name-calling), or other safety violations are the only times that we ask patients to leave temporarily. A common ground-rule breaking behavior is verbal, for example, a patient in the Punitive Parent mode directing a negative judgment at another. In this situation a ground rule reminder can be accompanied by recognizing the maladaptive

mode the patient is in (usually a dysfunctional parent mode) and its effect on the group.

### **Therapist Behaviors when a Mode Threatens the Group**

Modes that have strong negative effects on the group must be addressed. Sometimes a ground rule reminder is not enough to stop a disruptive behavior and the underlying need the behavior is fueled by must be addressed.

#### **Example**

In an early group session Kathleen got up and threw her chair down toward one of the therapists saying “This is bullshit, I am leaving.” Joan, who was sitting next to her quickly got up and moved toward her to pick up the chair saying “Kathleen, throwing chairs at people is not allowed here.” Ida made eye contact with her and said in a caring voice, “Kathleen, we want to hear you, so please don’t leave as you are an important part of this group. If you leave we will lose our connection with you and I don’t want that to happen.” Kathleen stopped and thought for a minute, then sat down on the chair that Joan had turned back up. She stayed without further disruption and reported later that being told she was an important part of the group had a significant positive impact on her.

It was important in this example, and in similar group situations, for one therapist to meet the *group’s need* for safety by asserting the ground rules even though it had little effect on the patient. It was also important for the other therapist to meet the *patient’s need* for connection and acceptance, which was underneath her Angry Protector mode behavior.

A patient in Angry Protector mode may sit in the group with rejecting body language that is easily noticed or ignore the group and give hostile verbalizations if questioned.

### Example

Ken said he was in the Healthy Adult mode, but sat with arms crossed across his chest and a blank expression on his face. When peers gave him feedback that they were worried about him and his lack of participation, he stated “I don’t need any of you, we have nothing in common.” Peers continued expressions of concern seemed to bounce off Ken with no effect. Since group members’ efforts at empathic confrontation were not effective, the therapist had to step in. Ida asked him if he realized that he was pushing everyone away with his disparaging comments. He said “Yes.” She then asked if this pattern of pushing others away was common and worked for him. Ken again answered “Yes.” Ida then became more confrontational (but still empathic as she identified the underlying need) by referring to information about him that the group had: “So pushing everyone away back home, having no people in your life, and feeling empty had nothing to do with the three times that you swallowed antifreeze to kill yourself.” With this intervention he responded almost tearfully, “Yes, but the people here don’t care about me either.” He then told us about hurt feelings from a disagreement with the fellow group members who were expressing concern about him. He had risked becoming close to them and now felt rejected. His expression of feeling hurt (vulnerability) allowed them to discuss the disagreement, resolve it, and reaffirm their caring feelings for each other.

One caveat to this approach is that the therapist should only use personal information that has been shared with the group by the patient unless explicit permission is obtained. In the above example this information had been shared previously. Many occasions arise in group where a piece of personal information that has not been shared with everyone is important to the group understanding a mode reaction and to the therapist being able to empathically confront. In that situation you can ask a patient if it is alright to share something with the group by vaguely referring to the information in a manner the patient will understand but does not reveal much to the group. For example, “John, would you be willing to tell the group about the experience you had that relates to what we are talking about?” With a patient you think might be reluctant to share this himself or will not know

exactly what you are referring to you could say, “John, would you tell the group, or would you like me to tell them about your related experience?” We rarely have patients say no, even though it is clear that they sometimes have little idea what experience of theirs we are referring to. Their willingness to go along with what we suggest indicates that they trust us to have their best interest at heart. It may also be that we intuitively do not try such interventions unless we think there is enough trust.

### Patient example

It is particularly important to ask the patient to share additional information if their unexplained reaction is affecting the group negatively. In the session after the “Identity Bracelet” exercise, we ask the patients to return in imagery to the experience of receiving the beads. On this occasion the group had been particularly positive during the exercise, which was led by Annie, a patient who is often in a leadership role. When we were discussing it, Annie declared, “It was all fake, you guys don’t know me.” She went on to question many other things about the genuineness and value of the group. Joan knew that Annie had just heard that her father would not be visiting as promised for her 18th birthday. They had reunited recently and she had discussed her love for him and hope about this visit in a recent group session. In response to Annie’s declaration, the rest of the patients went into Detached Protector mode or, in the case of a patient with comorbid Avoidant Personality Disorder, overt anxiety. Joan saw this as an occasion for empathic confrontation along with a request to share information. “Annie, I think something else is going on here related to the news you received this morning. May I tell the group briefly what happened?” After Joan told them, there was some nodding from other patients and the tension in the room decreased. Annie went on to first vent her anger about her father in an Angry Child manner, then her Vulnerable Child hurt feelings about her father’s repeated abandonment and the repercussions for her as an adolescent. This was information that she had not previously shared with the group or therapists. This stimulated the rest of the group to discuss similar Vulnerable Child feelings related to abandonment themes with

parents. The group was able to close having moved back to a place of cohesiveness with everyone understanding that Annie's rejection of them had been the Angry Protector mode in response to her father, not them.

It is not always possible to get through the Angry Protector mode in an overt way even with accurate empathic confrontation. When efforts to reach out seem to fall on deaf ears, it is good to keep in mind that the Vulnerable Child behind this angry wall is listening, watching, and longing for connection and the Angry Protector mode is assessing for safety. A warm and compassionate stance and tone is still being registered and having an impact. Later in the session the patient's mode may be moved by the group's work, or he/she may be able to stay and let the work of the group go on around him/her until he/she is able to join in or the session ends. Since the needs underlying the Coping modes are those of the Vulnerable Child mode, it is important to remain flexible and creative in finding ways to meet the need. For example, the therapist might give the patient a pillow to hold or a shawl to wrap up in with the acknowledgment that it is okay to take care of him or herself and that they are welcome to join the group again more actively as they are able to. Our invitation to add protection always includes the rest of the group as they may be reacting to the Angry Protector presentation. Sometimes we ask the patient in Angry Protector mode (same thing with Bully-Attack mode) to go into a safety bubble, while the group goes on. We do this in the hope that some added external safety may allow them to drop some of their protective mode. Other patients can move their physical proximity, or one of the therapists will sit next to or in front of patients who feel frightened. We always try to remember that, anything we do with one member in a group, demonstrates to the rest what will happen if they have a similar presentation or experience. The therapists as good parents want to demonstrate that everyone can be helped to feel safe and that we will keep the group safe.

A patient in the Bully-Attack mode needs a somewhat different approach from therapists including strong limits. As previously stated, attacks cannot be allowed and if a patient cannot contain such expressions, he/she may need to be asked to leave the group temporarily. Sometimes a therapist sitting by the patient in Bully-Attack mode can gently and empathically confront by referring to the feelings underneath the mode (e.g., fear or hurt) and

remind the group as a whole of the protective function of this mode, its need for limits, and our willingness and ability to provide them.

### Example

A large male patient would sometimes sit up very straight (up to his full six foot- seven inch height) and say “Yes, I am in the Bully mode and I have stuck my knives in.” This statement was delivered with a scathingly angry look directed very clearly at another patient. One of the therapists was sitting next to Jim and patted his arm saying “We know you get in Bully-Attack mode when you fear rejection. We understand how much pain you have had from rejections.” The other therapist held her arm out with hand up saying “But it is not okay here to glare like that at Jen.” Jim “Hmph’d,” turned away from Jen and looked at the therapist next to him instead, leaning a bit toward her. As the group went on and the glares of this patient recurred, the therapist again patted his arm saying, “I know that you are feeling afraid. I am right here with you.” Jim again stopped glaring and Ida patted his arm again at times through the session. Acknowledging the “elephant in the room” and the therapists’ reassurance that the group would be kept safe was enough to restore a working group environment.

This is a good example of a gentle empathic confrontation combined with limit setting. If it is not responded to, you can increase the confrontation as needed. The interventions just described were met with a verbalization of “hmph”, accompanied by what looked like some acknowledgment of the limit and of the understanding being offered. At least they were not disagreed with and they did lead to an end of Bully-Attack mode. Interventions like these by the therapist serve a number of purposes. They set a needed limit to protect the group as a whole, let the patient know his/her feelings will be accepted, but not aggressive behavior, and they provide words for some of the feelings that underlie these maladaptive coping modes. Sometimes the therapist stating the patient’s underlying need is enough to have the group respond with compassion and understanding. This can be very effective in getting through the Coping mode to the Vulnerable Child mode.

If a patient is not able to stop Bully-Attack mode behavior, they must leave the session until they can get control and are expected to come back



into the session once they do. Safety and reinforcement concerns often must be balanced by the therapist. When the therapist returns, the group must be briefly informed, within the bounds of confidentiality, about what happened. This is another situation where the therapist needs to get the patient's permission regarding what private information is acceptable to be shared with the group. When the patient returns, he/she is expected to wait for a break in the discussion and then acknowledge what has happened. If he/she is no longer in Bully-Attack mode, the underlying Vulnerable Child issue can be discussed and responsibility taken for any residual negative effects on other members (e.g., a sincere apology). Experiences like these are important emotional learning opportunities, showing that vulnerability is responded to positively and not punished, and that the Vulnerable Child does not need the Bully-Attack mode to protect them in an unhealthy way.

Sometimes gentle reminders and even firm empathic confrontation fail. On these rare occasions therapists may need to get help to maintain safety, like good parents must sometimes do when the situation requires it. In inpatient groups, as a last resort, we will get nursing staff help to physically remove a patient who will not stop a verbal or physical attack. We have not had this occur in an outpatient setting, but if it did, we would seek help from other clinical staff and security if necessary. We will take whatever action is necessary to protect the family and its "vulnerable children." Patients who leave the group temporarily due to behavioral transgressions are allowed to come back and make peace with the group including a recommitment to the ground rules. They are expected to have a plan to prevent a recurrence of the unacceptable behavior. It is reassuring to group members to see that behaviors that hurt others are limited by the therapists and, at the same time, that the person is still valued, not labeled "bad" and that the group does not give up on them or kick them out. For some patients, it is an example of how "good parents" would have protected them from bullies in childhood. This is one more emotional learning experience provided by the group due to its family-like function.

These examples demonstrate the efficacy of having two therapists to maintain safety and effectively manage the multiple modes and needs of patients with BPD. Taking whatever action is needed to maintain safety and the group's boundaries is an important therapist behavior as it demonstrates that the therapists will do what they say they will and that they are capable of keeping the group safe. It is important that the ground rules are never ignored and that violations are addressed. A **vocal tone** which conveys warmth and genuineness is one important medium for limited reparenting,

but so is a firm voice with increased volume to set limits in. The ground rules and the therapist's enforcement of them are regularly described as part of the foundation that keeps the group family safe. This has an impact on the significant mistrust/abuse schema of BPD patients which fuels the Coping modes that we need to get through in order to reach the Vulnerable Child mode. Patients with BPD were usually not protected in their childhood environment, so the experience of being protected by the group therapists is an important aspect of healing the Vulnerable Child mode. In individual therapy we are also protective of patients, but rarely need to literally act to protect them from others aside from imagery work. The kind of literal protection from others the group therapists provide may be one of the factors that amplify limited reparenting.

### **Therapist Behaviors to Respond to Conflicting Modes and Needs**

A core concept in ST is that the therapist's interventions (limited reparenting) match the mode a patient is in and attempt to meet the underlying need of that mode, or in the autonomy stage, help the patient get their need met outside of this relationship in a healthy way. Adaptive reparenting based upon need is further discussed in Chapter 11. A primary adaptation that a group requires is that the therapists must match their interventions to multiple modes, complicating mode flips, and sometimes conflicting needs that a group of patients present. Interventions for each mode are discussed in Chapters 6 to 8. Here we will look at the general therapist approach to conflicting needs. Having eight patients to respond to and work with instead of one means, in practice, that you will usually have many different modes present in a group session and their underlying needs will conflict. The dilemmas one therapist could have in responding to conflicting modes and needs are apparent from a look at Table 4.1 on the basic needs of core modes.

Therapists must find ways to balance their responses to the different, and at times conflicting, needs of group members and the collective need of the group. Therapist behavior should mirror the way a good parent handles siblings in a family. The reparenting message here needs to be "All of you matter and are important, no one will be sacrificed." This message is quite different to what BPD patients heard in their early environment where the message was some version of "Your needs are not important, you are wrong

**Table 4.1** The relationship between unmet childhood needs, schema modes and therapist interventions

<i>Unmet childhood needs</i>	<i>Schema mode</i>	<i>Therapist intervention</i>
Secure attachment – includes safety, predictability, stable base, love, nurturance, attention, acceptance, praise, empathy, guidance, protection, validation	<b>Vulnerable Child</b> Experiences intense feelings, emotional pain and fear become overwhelming and lead to flips to maladaptive coping modes that are identified as other BPD symptoms	Meet the listed needs, comfort, soothe, reassure, wrap in blanket, connect with Vulnerable Child
Guidance, validation of feelings and needs, realistic limits and self-control. Freedom to express, validation of needs and emotions	<b>Angry Child</b> Vents anger directly in response to perceived unmet core needs or unfair treatment	Listen, allow the emotions and support venting, help them identify unmet need they are responding to. Identify the Vulnerable Child need
Realistic limits and self-control, validation of feelings and needs, guidance	<b>Impulsive/Undisciplined Child</b> Impulsively acts based on immediate desires for pleasure, without regard to limits or others needs (not related to core needs)	Set gentle yet firm limits, guide, teach healthy release exercises. Identify Vulnerable Child need
Spontaneity and play. Lack of love, nurturance, attention, validation, acceptance, safety leads to underdevelopment of the Healthy Child mode.	<b>Happy Child – underdeveloped</b> Feels loved, connected, content, satisfied	Take pleasure in and show it visually, invite out to play, play with
Parent modes suppress and reject the needs of the child, applies to any need – particularly love, nurturance, praise, acceptance, guidance, validation.	<b>Punitive Parent</b> Restricts, criticizes, and punishes self and others	Stop the message, set limit and eventually banish this mode Support and connect with Vulnerable Child needs

<p><b>Demanding Parent</b></p> <p>Sets high expectations and level of responsibility to others, pressures self or others to achieve them</p>	<p>Challenge the message, reassess what reasonable standards and expectations are</p> <p>Support and connect with Vulnerable Child needs</p>
<p>Any unmet childhood need can produce one of these Maladaptive Coping modes. They are versions of the survival responses of Flight, Fight and Freeze. When they were triggered a lot in childhood, they become your usual way of responding to psychological threat. They happen automatically. You can learn to be aware of them and eventually to make a choice of how to cope that fits better with your adult life. That is the goal of therapy and requires developing your Healthy Adult mode.</p>	<p><b>Avoidance</b></p> <p>Pushes others away, breaks connections, emotional withdrawal, isolates, avoids</p> <p><b>Overcompensation</b></p> <p>Coping style of counterattack and control. Sometimes semi-adaptive</p> <p><b>Compliant Surrenderer</b></p> <p>Compliance and dependence – gives up own needs for others, people pleasing</p> <p><b>Healthy Adult - underdeveloped</b></p> <p>Is able to meet needs in healthy way</p>
<p>Autonomy, competence, sense of identity</p> <p>Lack of childhood needs being met leads to underdevelopment of HAM. The more unmet needs, the less HAM development.</p>	<p>Identify underlying need, connect with VC, encourage thawing</p> <p>If angry protector, set limits and try to connect</p> <p>Limit damage to group</p> <p>Help patient identify underlying need and evaluate whether the coping mode meets it</p> <p>Connect patient with his/her Vulnerable Child</p> <p>Identify unmet need, evaluate whether coping mode meets it, help get need met.</p> <p>Connect with Vulnerable Child</p> <p>Acknowledge autonomy</p> <p>Invite use of competence in group</p>

to have needs or you are too needy.” We frequently hear from our patients that expressing their needs as young children by crying was met with the message “Stop crying or I will give you something to cry about.” When we attempted to discuss needs in our first BPD group we were surprised at the amount of anxiety this topic caused and how vigorously the group worked to avoid the topic. The education about the role of unmet childhood needs in the development of BPD that is provided in the education stage is very helpful in allaying this anxiety.

Because so many core needs were suppressed, BPD patients frequently go through a period in which their awareness of their needs is high and can be perceived as “greedy” by therapists. It is important to remember Young’s idea that they are “needy” rather than “greedy” and it is understandable given their emotional deprivation in childhood. This is further amplified by many having what is probably a more sensitive and reactive temperament and having needed extra amounts of loving responsive care. If you are one therapist, the strength and number of needs you are presented with can feel overwhelming. This is another point in group where a second therapist can play an important role in providing a limited reparenting response to all.

### Therapist tip

One can quickly observe the effects in a group of therapist interventions that are interpreted as denying or asking a patient to suppress an actively felt need. An example is asking a patient who expresses some fear about an exercise to “Hang in there, it will be okay.” Indeed it may be “okay”, but that patient is likely to respond with a coping mode like Detached Protector or even Angry Protector by the time the exercise starts. A subtle change in therapist intervention which has a markedly different effect would be to say, “I know new exercises can be scary, would you be okay coming to sit closer to me or by (name a patient or the other therapist) and maybe holding a pillow and I will keep checking on you as we start the exercise? . . . Or is there something else you need to feel safer?” Needs that are not addressed or ignored feel like invalidation to patients, and a Maladaptive Coping mode or Angry Child response is very likely. Quickly addressing their need takes less time and is more therapeutic.

Sometimes the conflicting needs present are clear. An example of this would be a time in which a number of patients are in the Vulnerable Child mode and one or two are in Angry Child mode. The group therapists in this situation need to protect and comfort the Vulnerable Child and hear and allow the Angry Child to vent his/her anger. This can be difficult to do at the same time without a second therapist in a BPD group. In a higher functioning group, with patients who have stronger Healthy Adult modes, one therapist with the help of the group may be able to manage. We take a shaping response to meeting Vulnerable Child mode needs. Early in therapy, if the need can easily be met in group this is done. A core Vulnerable Child mode need is connection. A variety of ways to meet this need that do not take a lot of time or disrupt the ongoing work of the group are described in Chapter 7. Often the need is for comfort or protection and the patient can be asked to move to sit closer to a safe person and/or to hold a pillow or wrap in a soft blanket. “Louder” expression of needs by the Angry Protector mode or Overcompensating Coping modes or the Angry or Impulsive Child modes may require empathic confrontation and/or limit setting as in the examples earlier with Kathleen, Ken and Jim.

It is important to keep in mind that when BPD patients begin therapy they have limited ability to regulate emotion. A lot of mode flipping occurs and the group itself may evoke more intense emotional responses along with more intense coping mode responses. More active therapist interventions are consequently required early in group and it is important not to respond in a manner that will evoke guilt or shame in the patient who may be doing the best they can. This is the kind of situation in which therapist schemas and modes can be hooked.

### Example

In the second session of group, a new member, Val, started a session with a complaint about her patient-mentor (Jane) saying, “I thought this was supposed to be like a family and finally I would have a place to be accepted, but after what Jane said to me I know it is not and I intend not to talk again.” At that point Jane got up and walked over to Val yelling at her, questioning the complaint, and expressing anger about Val’s comments. As soon as this happened, Joan also stood up to match the intensity of Jane and said to her, “I expect more from

you Jane, you are a mentor, you know better than to act like this.” Jane sat down, but through the rest of the group looked angrily at Joan and refused to engage in any discussion. She was also shaking her leg and appeared agitated. The situation with Val was a misunderstanding that some of the rest of the group helped clarify and resolve. Joan was the only therapist in that group session but had a visiting schema therapist observing. After the group ended, the visitor pointed out the Angry Child mode behavior of Jane in response to her need for Joan’s validation of her feelings not being met. Joan realized that her Demanding Parent mode had been triggered and came through loud and clear in her response to Jane. Joan was able to acknowledge this later to Jane and apologize for not responding to her need. Jane easily accepted this and the break in connection between them was repaired. This example demonstrates a therapist mode being hooked, how to repair it, and the important role a second therapist in the room plays.

We make a huge effort to help patients identify and express needs and to meet them as this is a large component of how the Vulnerable Child mode heals. It is also a critical aspect of the early reparenting that attachment develops from. We want to match our reparenting style to the developmental level of patients; not doing too much or too little. Like childhood parents, we will make mistakes, but these can be discussed as a learning opportunity for all. By the autonomy stage of group we want patients to be able to identify their own needs and take adaptive steps in their environment to get them met in a healthy way. As in life, however, the “baby steps” cannot be skipped.

### Example

A particularly challenging example of conflicting needs occurred in one of our groups – a patient with frequent pseudo-seizures (Robin) with the need to belong and attend group. Some other members experienced the seizures as startling or distracting (as did the therapists) and felt frightened. Initially the group therapists explained the seizures as a coping response and reassured the group that there was no medical danger. We all then tried to ignore them. After a number

of sessions, the therapists realized that in ignoring the problem of conflicting needs, they were ignoring the needs of seven of the patients and modeling some “bad or demanding parent” behavior (i.e. ignoring and possibly invalidating their feelings). We realized that the situation had become a kind of “elephant in the room”, that no one acknowledged. This situation reminds many patients with BPD of sitting at the dinner table with visible bruises from a beating or tears from feeling unloved that no one acknowledged. In healthy families “elephants in the room” are acknowledged and in group sessions the therapist as “good parent” must do the same. We introduced the topic at the beginning of a session, which seemed to create general anxiety and discomfort. We were also somewhat uncomfortable, as we knew it would be difficult for the patients to discuss and we had no easy solution to offer regarding the conflicting needs. With strong encouragement, two patients said that they startled every time a seizure started and that it distracted them from the group focus and raised their anxiety level. One of the therapists also said that she was sometimes distracted but wanted to find a way to keep Robin in the group. Robin immediately went into the Compliant Surrender mode, offering to leave the group, although she also said how important it was to her to be part of it. Several patients spoke up, not wanting Robin to leave. The patients who risked sharing their discomfort flipped into Punitive Parent mode saying things like, “I knew that I shouldn’t have said anything. I was bad not to keep quiet, now everyone will hate me.” The therapists were active in directing the group in a discussion of their varying needs, the mode flipping, and how the “family” could work to find a good solution. During the discussion we had to intervene to keep Robin from leaving. We ultimately came to the decision that the positions of patients in the room could be changed to remove those who startled from direct vision of Robin. It was also decided that more than three seizures in 30 minutes would require Robin to leave the group for that session. This solution partially met the needs of all and came from the group members.

The group process from this example of “opportunity work” was a fruitful one as it gave patients an experience of the therapists doing what we said we would; finding a solution that did not sacrifice anyone, allowing conflicting



needs to be discussed in a way that no one felt judged, and allowing the expression of feelings without penalty.

After this negotiation, Robin revealed to the group that she was sexually abused by an older brother for years who threatened to kill her parents if she did not keep quiet. Her brother was, in general, a bully in the family who was appeased rather than appropriately controlled. Robin sacrificed herself in her mind for the good of her family at great expense to her emotional well-being. No one acknowledged the increasingly deleterious effects on her until the seizures began. Even then, the abuser brother was allowed to stay in the family while Robin spent much of her young adulthood in psychiatric hospitals. We enacted a solution regarding her seizures that sacrificed no one and gave Robin the experience of her need being made a priority. In addition, the therapist's setting firm limits for patients in the Bully-Attack mode earlier in the group's development was a very important experience for Robin of being kept safe. This led later to her demanding this safety from her family in terms of her brother's presence at family gatherings. This discussion prompted other patients to talk about early experiences of lack of safety, not being protected, or being sacrificed and how this affects their interactions with others today. Two women brought up how not having been kept safe meant for them that they don't know how to do that now and that it often led to unwanted sex because they surrendered in situations that felt dangerous. The group was able to discuss, in a way that applied to all of them, how surrender as a coping strategy develops from childhood needs not being met and how bad the effects of using surrender can be. The session also demonstrated the power of the group in coming up with a solution that addressed the needs of all. The therapists, of course, underlined and pointed out all of these emotional learning experiences and how they contradict schemas involving mistrust, defectiveness, emotional deprivation, and lack of belonging. It is helpful for therapists to regularly encourage patients to write about the emotional learning experiences of group and to recall the positive feelings that accompanied them (e.g., from this session; feeling protected in the group, valued)

In summary, all patients are accepted in whatever mode that occurs, but if the group as a whole is affected negatively, the therapists will set limits like good parents. Over the life of the group, patients will be asked to take progressively more responsibility for managing their mode-related behavior themselves, but in the beginning this is a therapist's task. In fact, mode management plans are a specific component of the GST program for

BPD (described in Chapter 6). Obviously many judgment calls are needed about how much group focus is directed at a given patient and for how long. The therapists need to decide whether the disruption in agenda presents: an emotional learning opportunity to be seized, a negative coping behavior to avoid reinforcing, or a distraction to get through. The mode that a patient presents may also fit right into the agenda for the session and in that case can be the content that is used. The group can be included in the discussion of whether to switch focus or stay with it when it is an issue that applies to others. Including them in the decision is an example of one of the many ways to demonstrate to them that they matter and their feelings and opinions are important.

### **Shape Self-Disclosure and Group Involvement**

Just as it is important for therapists to find ways to acknowledge and accept the feelings and needs of whatever mode each patient is in, they must also work with the effects of modes on their current level of sharing and/or participation in the group. We approach this with the idea of progressively shaping the patient's responses into greater involvement.

#### **Examples**

One example is the patient who is very quiet in group who you know to be struggling with social anxiety, avoidant personality features, or perhaps the flare-up of a Detached Protector mode. She can be included by acknowledging her presence alone, noting her nods to the statements of others, and elaborating a bit (e.g., I see Suzie nodding her head, she also knows what it is like to feel frightened or scared by the Punitive Parent). Such statements demonstrate acceptance of Suzie's level of participation, reinforcement of the participation, and a "nudge" to the Detached Protector mode by calling attention to her response. Another variation would be a comment that includes a quiet patient with the rest of the group such as saying, "I can see by her nod that Suzie is with us too, she knows what it feels like to be left out in a family."

Comments like this can increase group cohesiveness and individual patients feeling of belonging. If a patient is very frightened or anxious in a session, one of the therapists can make a number of suggestions, for example, she can be asked to put herself in a “safety bubble” to be able to stay in the group or to move closer to the therapist or a protective peer. The patient taking one of these actions should be positively reinforced as it represents her acknowledging a need and acting to get it met while also making effort to stay with the group.

### *Homework*

We also use a shaping approach in our response to patients’ completion of homework. We want to get around the failure schema so prominent in BPD patients by introducing the idea of “trying”; explaining that making some effort is what defines success to us. For example, it counts early in the group’s history if you “thought about the homework” or became aware of a barrier to completing the assignment (e.g., the topic triggered Demanding Parent mode and the patient felt paralyzed). This shaping is important as a way to encourage patients who fear exposing themselves to failure by attempting a homework assignment. If not attempting homework is a repeated issue, it can be referred to individual therapy for discussion or it can be approached in a global way in group by a supportive discussion that engages peers to provide ideas from their experience about what the difficulty is and what solutions might be. We have found that the failure schema can be so strong in these patients that they may even state that they failed when they have done the homework completely correctly. At the cognitive level we reason with them about their performance on homework and the impossibility of being wrong when homework asks about their perceptions. We always praise effort and success to balance criticism from dysfunctional Parent modes.

### *Example*

Matt said he had “not done the homework right”, was extremely anxious, did not want to discuss it, and asked to leave the group due to his anxiety level. Joan helped him take a few deep, slow breaths to calm down, asked him to share his answer to one question and gave

him feedback that it was correct. She encouraged him to share more, but he again stated that he did not do it right. Joan stayed with this for a few minutes as it was clear that Matt was about to bolt from the group and she knew this was an issue many others shared. She asked to see the homework and he gave it to her with reluctance. She reviewed it and declared that it was very successful. It took much validation from Ida and the group for Matt to take in that he had not only done the assignment correctly, but had done a very good job. It was a good example for the group and Matt to see the limiting and distorting functions of schemas. It also became a reference point for the group related to the failure schema; a shared experience that they could be reminded of when another patient reacted in a similar manner.

### **Group Therapists must be Jugglers**

Group therapists must simultaneously pay attention to ST goals, process, and content; juggling the three depending upon the stage of the group, the modes patients are in, and the particular triggers of a given group of patients. There is not one correct choice to make among these different aspects of ST. It can be a good choice to stop in an early education session to focus on connection when a patient says “I know other people here don’t have these problems as they look normal.” You can then return to education. A critical factor is not to lose your connection to the group while presenting content and not to lose complete track of the content goal of an earlier session by following the trail of one individual’s presenting mode if it does not apply to the majority of patients. As a group therapist, you cannot get away from the balancing act of goal, content, and process. When you have the added complexity of BPD patients, you will hopefully have a partner in the juggling act. Of course, trading “balls” in juggling with a partner can also add complexity to the task. Fortunately, the schema therapy style of “being genuine and human,” allows us to stop the action in group if we need to consult our co-therapist, or the group, and to not be perfect. For example, we might ask for a brief “time out” from action to look with the co-therapist and the group at what has just happened, or to reflect upon the conflict between current group need and scheduled content. We can also just ask our partner for input or help.

## Management Issues

### *Dealing with the modes you trigger*

Therapists also trigger modes, particularly Demanding or Punitive Parent mode reactions. When this occurs, it can provide information about triggers of those modes that patients need to be aware of. It may also provide a mode role-play opportunity. It is important for therapists not to react defensively when told that something they have said or done has triggered a Maladaptive Parent mode. One should ask the patient if they know what exactly they were responding to, for example, tone, facial expression, particular words. The therapist being willing to look at what they did that hurt, for example, the Vulnerable Child mode of a patient and to apologize for it, can be a powerfully healing experience. Your apology should take the form of, “I am sorry that something I did hurt your little child. I never want to do that and I would never intentionally do it.” It makes the point experientially that we express verbally that it is *not* okay to hurt the Vulnerable Child mode. It is important to be alert to triggering parent modes as we don’t want them to go unnoticed and inadvertently reinforce or maintain early maladaptive schemas.

### *Limiting conflict*

A therapeutic group experience for BPD patients requires that a safe and supportive family structure is developed and maintained by the “parent-therapists.” The group’s ability to tolerate emotional expression must be developed along with trust in the therapists. The group therapist must be ready and able to set firm limits on Angry Child or Punitive Parent verbal attacks on peers and prevent physical attacks on anyone. Experiences of being attacked, abandoned, ostracized, and rejected would strongly evoke affective responses that represent patients’ schema modes, but we think that the experience of being protected by a competent therapist parent is a more important therapeutic experience in the first six months of a group. We expect and want affective experiences to be triggered, as the group potential to evoke affect is one of its proposed augmenting factors, but we do not want re-traumatizing experiences to occur. Participation in a group provides enough emotional activation. Negative experiences that are re-traumatizing need to be prevented as much as possible by the therapist. Any broken connections within the group must be repaired in a timely manner to keep

the culture of the group growing toward a healthy family and not recreating the unhealthy environment of their childhoods. The Vulnerable Child mode of patients needs to know that the therapists will protect them from such experiences and not abandon them. An effective group therapist must be able to set limits when needed and at times balance the group's emotional intensity with techniques such as the Safe Place image (EXP 10)(if early in sessions use the Safety Bubble EXP 9), or the simple instruction that everyone stop and take a deep breath. The group therapist must be able to set and maintain the boundaries of group interactions.

In addition, it must be possible for the Angry Child mode to vent safely in the group setting knowing that the therapists will take care of any patients in the Vulnerable Child mode. Importantly, the therapists and group members must find ways for these different needs – expression of emotion and safety – to be met without “sacrificing” anyone. Accomplishing this provides cognitive and experiential antidotes for schemas of subjugation and self-sacrifice and the maladaptive coping mode of Compliant Surrender.

### Example

Katie, at the hint of a peer expressing anger, assumed that a conflict was coming and declared “I can’t handle conflict” in a frightened voice. Ida asked if she would like to come over to sit by her and Katie quickly ran over. After the venting and conflict resolution that was needed occurred, Katie said, “Wow, I was scared, but this turned out okay, even good. I never experienced it being safe to disagree before. In my house someone would be bleeding by now.” Over time in group, Katie risked disagreeing with a peer and setting a boundary rather than giving up her need.

### *Dealing with crises*

In working with BPD patients whose lives are prone to crisis, especially in the beginning of therapy, it is inevitable that patients will, at times, bring in what they consider to be a crisis as the group begins its session. It is not either therapeutic or realistic to think that a crisis can be put aside for the scheduled work of the group. However, we try not to spend more than 15 minutes on one crisis issue, unless the whole group can relate and are

engaged in the process. We usually move the crisis situation to the white board for a “Circle monitor” analysis. This actively brings the group into the assessment and need identification process. We start by validating the patient’s feelings and inquiring as to the need involved. It is important to distinguish whether a schema mode is involved or it is solely an external situational emergency or problem. This determines whether you address the mode first or go to assisting in some way if you can with the emergency or problem. For example: Pam might come into group very distressed because she has received an eviction notice, be in a Healthy Adult mode and be able to respond to direct assistance with the situation. Pam may later come in having received an overdue notice on a credit card payment that she forgot to mail but has the money for and be crying and blaming herself harshly, verbalizing how “stupid” she is, and how she doesn’t deserve to live. In the later situation we would need to help her focus more on helping her fight against her Punitive Parent mode than problem solving.

We evaluate whether self-injury is an issue and, if so, make sure a safety plan is in place and check on related aspects of mode management, making sure they are implementing mode management plans that have been developed. Often they are not using their plans and a reminder is helpful. This also provides vicarious learning for the group. It may be necessary to do a short group exercise to reduce distress levels as group begins (e.g., a safe place image or “safety bubble exercise”). It is good to bring the group into the discussion by asking for input or labeling the category of the crisis and referring to successful solutions that the group or members have used for similar situations or feelings. We use the Circle monitoring procedure to pull in the group and to focus the problem solving that the group does. The Circle is also a “short-cut” to get to the heart of the problem – the unmet need. You can brainstorm and problem solve as a group or do mode work with the crisis as a jumping off point. Group members develop a deeper understanding of how to meet the needs associated with each mode in the process of helping each other deal with a crisis. For example, they learn how to help another member vent and re-channel feelings of anger when in the Angry Child mode, get in touch with feelings and access needs for soothing and caring when in the Detached Protector mode or combat the Punitive Parent.

It is good to try to wrap up the crisis work by asking the patient whether now that she has a plan she can be present while the group moves on with the planned focus of the session. One of the therapists may want to go sit by the patient with the crisis for support and check in on her

distress level occasionally as the group proceeds. Remember, it is usual for patients in crisis to use old maladaptive coping strategies, often some form of Detached Protector mode. At these times they are also vulnerable to flipping into dysfunctional parent modes, providing an opportunity to look at the role of Demanding or Punitive Parent with the group. For example, saying to the group, "What do you think is going on with Pam's Punitive Parent mode right now? How would your Punitive Parent mode react? Pam, what is happening for you? Is there any mode flipping?" Crises are situations where having two therapists is very helpful since one can help by leaving the group briefly with the member to help them de-escalate if they are not able to attend to anything but their crisis. This is a strategy to use sparingly and to bring whatever happened outside the group back to it eventually.

### *Dealing with dissociation in session*

Our approach to a patient dissociating in a session depends on a number of factors. Is the dissociation disruptive to the group? This can occur if the dissociation is of the "flashback" re-experiencing type in which the patient is re-living a trauma actively. In this case, we act quickly to get the patient out of the dissociative state. We do this by getting them up and walking to do some grounding. One of us may move with the patient out of the group session briefly. When this occurs, it is important to return and do some brief processing in group so that the group is included in the patient's experience. We also consider how many of the group members experience dissociation. If it is more than half, the therapists may want to bring the person back to present moment orientation in the group. The others understand dissociation and the dissociating patient will feel more connected to the group. This should not become the whole focus of the session unless dissociation is a significant issue and applies to almost everyone. If the dissociation is "quiet" and of the detached type, which does not include re-experiencing, the therapist can do something to help the dissociated patient feel safe and to stay in the present. One of us would move to sit by that person and make them aware of our presence. For some patients this has meant holding onto the tail of the therapist's shirt or a piece of yarn or fleece as a connection. This approach addresses the underlying fear and need for connection of the Vulnerable Child mode. In general, we discuss dissociation as a version of the Detached Protector mode and look at the triggers and the effectiveness of the coping strategy involved. We also discuss the reaction the group has to the dissociation. Other patient



responses range from feeling abandoned to being supportive and nurturing and attempting to help the therapists work with the dissociated member. Dissociation usually decreases fairly quickly as ST work on the triggers for Detached Protector mode and how to prevent them progresses. Additional work on dissociation is covered in Chapter 7 on Detached Protector mode.

### *Patients with avoidant features*

Since avoidance is one of the major coping styles of BPD patients, and rejection sensitivity and approval seeking are so frequently part of their clinical presentation, Avoidant personality disorder or its features is a common comorbid condition that patients present with in groups. Our approach to avoidance is very similar, whether part of a separate personality disorder diagnosis or not. We draw patients in by questions directed at them or using information we know about them as an example of what the group is talking about (with permission for this from patients as discussed earlier in this chapter). In a way, this is “talking for them” to help them begin. When patients, for whatever reason, continue to present needs in an indirect manner or one that is alienating the group, one of us will go over to them in order to play a coach. We will whisper to them what to say so that they can experience how being more open elicits a positive response from the group. When patients are significantly avoidant, we make an extra effort to validate and praise them directly and will inquire about the content of their fears if they speak. We also engage them in vicarious learning. This could include role-plays of their situations in which others play all the roles, even theirs. They are able to first be an observer, thus reducing what may be disabling performance or approval anxiety.

### **Example**

Pat was a very fearful, avoidant patient who told us that most of her life had been spent with a beer in her hand. In group she described how non-supportive her mother was and how she repeatedly said to her in childhood (and even now) “You will never have a happy life.” Joan suggested a mode role-play with her Punitive Parent mother. It was clear that Pat became paralyzed at the suggestion, so a role-play was set up with the therapists and group playing all of the roles.

Joan played the good parent who was there to protect Pat. A student observer played Pat's mom. We chose the person least involved with the group to minimize any carryover of feelings from the Punitive Parent mode role to them as a person (more about this in Chapter 6). Pat's Vulnerable Child mode was played by one of the other patients, who sat behind Joan for protection. In the role-play Joan said a number of positive things about Pat and her worth and how she deserved to be treated. She also said a number of times, "Pat deserves to have a happy life." Pat watched the role-play very intently. At the end when she was asked about her reaction she said with much emotion, "I wonder how I would feel now if I had heard things like that growing up?" Ida countered with asking Pat what it was like for her Vulnerable Child to hear those things now and what had the most impact. Pat said, "It feels good. She likes it and the saying about deserving a happy life was best." Ida wrote that on a card and gave it to Pat as a tangible reminder.

This is a good example of the vicarious learning opportunities available in group and how this aspect of treatment can be especially helpful in early work with avoidant patients. This had a big effect on Pat's understanding of how much she was influenced by her mother's messages, how it "should have been different", and how her Vulnerable Child mode could have different messages now.

### *Patients with Narcissistic features*

In responding to patients with significant narcissistic features in group, we remember Young's point to see the patient as "needy" rather than "greedy." We do exclude patients with full Narcissistic Personality Disorder (NPD) because they do not fit well in all BPD groups as their entitlement tends to set them up as natural scapegoats with negative effects of the group process. We think treating this group of patients in a group could be beneficial, but in a mixed group with more than one person with NPD. We attempt to work in the same way we do with other patients. We empathize with the underlying pain (feelings of insecurity and defectiveness) that give rise to their coping style of overcompensation (expressions of superiority and entitlement) and identify and respond to the underlying need. Over time, as other patients see the underlying vulnerability, they will be less rejecting

of patients who present in this way. If a patient with narcissistic features is disparaging of the group, the therapist can again attempt to identify the feelings underneath (such as fear of rejection and need for connection) and address the way in which the patient is trying to turn the tables to get away from her vulnerability. The modes that arise can be dealt with in the same way as for a patient without narcissistic features. Sometimes the presentation is an Angry Protector mode rather than an overcompensating mode and can be dealt with accordingly.

### Therapist Tip

When a patient is being grandiose or monopolizing the group's time, we validate and set limits. For example, we might say "thank you for contributing so much information to the group, but right now the group needs you to take some time in a listening role so that we can hear about the experiences that others have had." Or "That is a really important insight, now we need to get back to . . . (name the issue the group is looking at), or simply, "I am so glad you shared that. Have any of the rest of you who have not yet talked today experienced that kind of situation?" These confrontations must be gentle so as not to engender fear that if you talk "too much" you will be criticized or cut-off. Group members watch how we respond to others closely and naturally assume (and may end up fearing) that they will get the same response. If they are avoidant, that kind of fear can lead to further shutting down.

### *Other disruptions*

Patients sometimes bring in a "pet peeve" of theirs, some repetitive issue or a long story that is very specific to them. Here the therapist as "director" comes into play. When these potential distractions present opportunities for meaningful mode work it is good to move it in that direction. When it is just a distraction that has little schema relevance and not much bonding value, it is better to validate the feelings and move on. If it is the presence of Detached Protector mode, then address the mode issue. Don't let the group divert for too long for no purpose, but try to respond in a non-judgmental and supportive way. Remember, in group you always have an audience for

your interaction with other patients. Observation of your reactions opens up vicarious learning experiences, so how you handle redirecting a patient will either “shut down” self-disclosure or facilitate it. When an avoidant patient brings up something like this (they rarely do) we will give them more latitude in order to reinforce them for sharing. When it is a long story from a narcissistic patient or an interjection makes it clear a patient is self-absorbed and paying little attention to the group, we point that out and are more matter-of-fact. We also use summary statements reflections to move the group along or wrap up a long monologue. For example, “It is clear that Lisa really enjoyed that experience and it has been fun to listen to her describe it. We probably need to get back to our discussion of how being in Detached Protector mode in group sessions is limiting”

### **Therapist Tasks Related to Being Healthy Adult Role Models**

The therapists are models of healthy parent responses for the group to base their Healthy Adult mode on. The patients’ experience of us as caring and validating parents is limited reparenting in action and one of the main active ingredients of ST. Their experience with us provides new learning opportunities and many healing experiences for the Vulnerable Child. We act as models for what Healthy Adult is for our patients and may be one of the only models they have experienced. This means that it is important to be human, including some self-disclosure of our schema issues or modes being triggered. We suggest using examples that do not include a negative reaction to any of the patients. An advantage of the co-therapist team is the help we can give each other in recognizing and responding to instances of getting “hooked” by one of our own schemas in response to a patient or issue. The co-therapist has a number of choices: they can give the signal that help is needed and help us regain a therapeutic reparenting position; alternatively, they could use it as an opportunity for healthy self-disclosure by asking their partner about what is happening or commenting on what they are observing. For example, “Gee Joan, I wonder if your Demanding Parent mode was involved when you gave the group the assignment of monitoring their mode ten times a day?” Patients report amazement that we have modes. This suggests that the didactic information that “everyone has modes” had limited effect on their unrelenting standards schema. The experience of us as flawed humans seems to have more of an impact. Modeling healthy and

respectful responses to disagreements or how to negotiate when in conflict is also valuable reparenting.

In the process of developing your co-therapist relationship, it is important to be connected with each other when working with the group. For some therapists this is done by checking in briefly before the group starts to be clear about the goals for the session and the plan for accomplishing them (this needs to be flexible as will be discussed later). Some therapists want to have a deeper connection that includes either connection at the Vulnerable Child level or a sharing of information about what your own Vulnerable Child fears or is touched by in the group. In REF 6 Cotherapist Connecting Exercise you will find an exercise for co-therapists to use for these purposes. One part of the exercise is for connecting at the level of the Healthy Adult mode and for sharing Vulnerable Child information. The exercise was inspired by an early training workshop of ours. When we first tried the Vulnerable Child mode exercise in a therapist workshop it appealed so much to the therapist pairs that they continued the exercise through the workshop break missing the yummy snacks the hotel provided. It is no surprise that schema therapists also yearn for deep connection and, although we expect that they have that in their personal life, it is also helpful when therapists are conducting GST together. GST is intense work due to the number of participants and the intensity of the emotion or energy that can often present. Knowing that you can signal your partner that your Vulnerable Child is being affected and you need some support is reassuring.

In conclusion, groups require of their therapists stability, consistency, flexibility, creativity, a loud or soft voice depending upon the task, a well-developed sense of fairness, a reasonable degree of freedom from schema issues, and a good support or supervisory group. Fortunately for us, GST does not demand from us that we do all of that perfectly all of the time.

# Some Basics of Group Schema Therapy

J. M. Farrell and I. A. Shaw

This chapter describes structural elements of Group Schema Therapy (GST) including the size of the group, length of treatment, and features of the group room. It also gives an overview of the basic components and overall course of the treatment and the types of interventions used.

## THE BASICS

### *Recommended patients for BPD focused GST*

**Inclusion criteria:** Patients with BPD, diagnosed either by clinician, BPD Severity Index (Arntz, van den Hoorn, Cornelis, Verheul, van den Bosch, & de Bie, 2003), or SCID-II (First, Spitzer, Gibbon, & Williams, 1996), who are motivated to participate in GST and able to commit to the length of treatment. In clinical settings outside of research, sub-threshold BPD patients could also be included.

**Exclusion criteria:** Patients with lifetime Axis I psychotic diagnoses, ADHD meeting childhood criteria, Antisocial or Narcissistic PD, inability to speak or read the language the group will be conducted in, or an IQ below 80. We use this IQ cut-off from our experience of patients with IQs below it becoming frustrated by difficulties keeping up with the group material. These difficulties often are perceived as differences and consequently activate defectiveness and failure schemas in a manner difficult to help with. In addition, we have found that with an IQ below 80 there is a higher

likelihood that the BPD diagnosis may be misapplied to symptoms better explained by impulse control problems of a different type.

### *Size of groups*

We suggest eight patients as the ideal membership for an all BPD group with two therapists. Ten is possible. With one therapist it is better to have six patients. This being said, we have been in situations with ten and even twelve patients and one therapist. The developmental level of the group and its particular composition make more difference than number alone. Again, the practical demands of clinical settings often determine size.

### *The therapists*

Ideally, as discussed in Chapter 4, there will be two therapists. The necessary training in ST and GST is presented on the website: [www.BPD-home-BASE.org](http://www.BPD-home-BASE.org). We think that GST is a more challenging modality than individual ST because of the addition of the strategic use of group therapeutic factors and group process as well as the presence of a variety of modes. In addition, an environment of safety and cohesion with BPD patients can be challenging to develop and maintain without specialized training.

*Therapist availability outside of group* In preparatory sessions we explain the availability of the therapists outside of group. We suggest following the general policy of your practice or clinical setting for availability as long as you are able to give patients some source of help for emergencies outside hours. Often patients with BPD are unhappy about having limited access to you. We express concern about their well-being and make sure that they have emergency resources. We also explain the reality of our limitations and the need for a balanced life. Our position on availability is informed by the Nadort et al. (2009) study that compared effectiveness and patient and therapist satisfaction with 24-hour therapist availability versus a plan like the one described here. The study found no significant differences between the two conditions in either effects or patient preferences. We also establish safety plans with our patients early in treatment. This begins to give them some responsibility for identifying their potential safety issues within various mode experiences. We help patients develop an emergency plan to prevent life-threatening crises. For the Vulnerable Child mode in patients we use transitional objects, voice recordings, notes, etc., to help them feel our presence at times of difficulty and when there will be a gap

in sessions for holidays. Joan gives group members a special glass bead on a cord to wear as a bracelet to remind them of her during absences. Ida will put notes in envelopes for each session that will be missed with a note of encouragement or a fun assignment, for example.

### *Closed or open groups*

Groups may be open or closed depending upon your setting and whether you are conducting a research study or clinical practice. There are pros and cons to each approach and we can only speculate about differential effectiveness since we have no comparative studies to guide us. When conducting a trial, we have closed groups. In outpatient practice we use planned additions to an ongoing group and prefer to add two patients at a time to give newcomers a “buddy” in the entry process. In the event of early drop out, it is possible to add replacement patients within the first 4 weeks of group. It can be difficult in inpatient settings to admit eight patients at the same time, so one solution there is to add four at a time, so you have equal numbers of new and senior patients. In settings with open groups we use a mentor system in which the newcomer is given a “big sister or brother” to help orient them and be a contact person for homework or other questions. This system works very well for ST as it gives patients in the senior role an opportunity to feel competent and flex their Healthy Adult muscles a bit. Being a mentor provides schema healing opportunities for defectiveness and failure. Many patients have told us that being a mentor was the first time that they experienced having value and being competent.

### *Recommended evaluations*

We suggest that you have patients complete the Schema Mode Inventory (Young, Arntz, Atkinson et al., 2007), BPD symptom measures: the BPD Checklist (Giesen-Bloo, 2005), which measures the perceived burden of symptoms. These should be given before treatment and at 6-month to 1-year intervals. A measure of severity of psychiatric symptoms such as the Brief Symptom Inventory (Derogatis, 1993) and a quality of life measure such as the World Health Organization Quality of Life (WHO QOL Group, 1998) are also very useful outcome measures.

### *Length of treatment*

A number of time frames are in use for GST. Our original randomized controlled trial (Farrell, Shaw & Webber, 2009) evaluated the effectiveness



of 30 sessions of 90-minute weekly groups over 8 months when added to 20 months of individual psychotherapy that was not ST. Thus, the total treatment length was close to 2 years, with 8 months of that period including ST. The clinical trial of individual ST evaluated 3 years of twice weekly, then weekly individual sessions. The effect sizes in the group trial were larger than the individual trial despite the shorter time frame. In the individual trial an increase in positive change occurred at the 18-month point. Pilot studies in inpatient settings evaluating programs of approximately 120 hours of group and 18 hours of individual ST over 3 months demonstrated. Effect sizes similar to those of the outpatient group trial. These studies are described in Chapter 12. The intensive program is being tested in a Day therapy format, which can provide a higher level of care in between traditional inpatient and outpatient. The collaborative multi-site study going on currently compares two combinations of GST and individual ST as shown in Table 5.1. One format is the somewhat traditional combination of one group and one individual session per week over 1 year followed with a tapering schedule over year two down to one session per week, then bi-weekly ending with monthly. The second format begins with two group sessions weekly and a bank of 12 individual sessions to be used over year one. The second year is approximately the same tapering schedule of the combined format. Comparing the two formats will give us additional information about the relative power of group versus individual ST or how much individual ST is needed to support GST. In clinical practice, shrinking mental health dollars may be the variable that determines which format is possible.

If this seems like a lot of treatment, one has only to look at the epidemiological data on the prolonged and intensive use of mental health services of BPD patients when they are not given planned treatment (Comtois, Russo, Snowden et al., 2003). One must also keep in mind that ST is an approach with the goal of recovery, not just symptom control. GST, with its growing evidence base (see Chapter 12 by Arntz), has the potential to be cost-effective and widely available. This would help to solve the problem of the demand for BPD treatment exceeding the supply of evidence-based options, particularly in public mental health settings.

The model of GST presented in this book manual used in can be any of these formats.

### *Length of sessions*

Our groups are 90 minutes long with a 15 minute break.

**Table 5.1** Formats for Group Schema Therapy

<i>Format</i>	<i>Year 1</i>	<i>Year 2</i>	<i>Totals</i>
Outpatient A- Group focus	Group 2 × week 12 individual sessions	Tapering schedule: 6 months weekly group 3 months bi-weekly 3 months monthly with 6 individual	121 group sessions 18 individual
Outpatient B- Combination group and individual	Group 1 × week, Individual 1 × week	Tapering schedule: 6 months of alternating individual and group 3 months biweekly 3 months monthly	63 group sessions 63 individual
Inpatient	3 months 10 ST group sessions weekly 1–2 individual sessions		120 group 12–18 individual
Day therapy	3–12 months 3 groups daily 2–5 days Weekly individual session Tapering schedule over the year		72–180 groups 12–45 individual sessions

### *Attendance*

A commitment to regular attendance is included in the ground rules. We ask patients to make every effort to attend all sessions and be on time. The same is expected of the therapists. The importance of and unique contribution of each member is emphasized, as well as the concern that the group has when someone just does not show up. The responsibility of members to the group and the respect that the group deserves are also discussed. Members are required to call a designated person if they are unable to attend a session.

If they do not call in, they will be called. This calling is handled primarily by the group members. Patients rotate monthly being the person who takes calls and who calls members who miss a session. If they miss two or three in a row and are not responding by phone, a letter will be sent emphasizing the need to contact the group. All group members will sign this letter along with therapists. If there is no response to this contact, a letter will be sent telling them that they will need to reapply for a group in the future.

If a member is not following the attendance guidelines, it should be discussed with her in the group (or due to non-attendance, it may be discussed without him/her) and the group will have input into how this is handled. Empathic confrontation first, followed by limit setting if necessary is recommended. Of course all of these responses need to consider the reason given for absences. A member being hospitalized, ill, taking care of a sick relative or friend, for example, should be responded to differently than a member who says "I forgot," "I didn't feel like coming," or "I went to a movie instead." The first set of reasons is acceptable, although the issues of self-sacrifice, healthy boundaries, and the need to care for oneself could be explored in the example of caring for others. In the case of the patient who "forgets," it could be due to overwhelming stress and, at first, the group could offer to help with reminder calls. "Not wanting to come" needs to be explored and "going to a movie instead" empathically confronted.

### *The group space*

The room the group is held in is important. It should be a large enough room to allow for the movement required in experiential work. We suggest a minimum size of 400 square feet, or room for 10 people to be seated in comfortable chairs. The kind of furnishing one might find in a family living room is ideal for a group therapy space. The less institutional the setting looks the better. Carpeting or area rugs to soften the room and indirect lighting, not fluorescent overhead lighting are preferable. We strongly suggest that you *not* hold sessions around large tables. Tables lend either a work or even courtroom atmosphere that BPD patients often do not respond well to. Of course, psychotherapists often have little control over space. These suggestions are for times when you can design the environment.

Chairs should be arranged in a circle with a reasonable amount of room around them based upon your cultural norms. As therapists, we always sit with an equal number of patients between us on each side and across from each other. We realize that after 25 years of specializing in all-BPD groups, we have been well-trained by our patients to notice things that may

seem to be minor but make a difference to this sensitive group of patients. They notice if you sit further away from them and if the “parents” are not equidistant. Our reaction to preferences like this is generally “Why not?” We are happy to do what works for patients when it is not harmful to anyone. We sometimes must ask people to move to allow us to sit equidistant, but they do not seem to mind when we give them the reason. In addition, it does have some advantages for therapists as it places us directly across from each other. This gives a good view for any signals we may need to send and receive to our therapist partner. For example, it is easy to nod when our partner makes a particularly effective intervention and when they look at us with an expression of doubt during an intervention.

We use a “safety corner” in the group room as a place for patients to go briefly if they feel they need to cut down on intense feelings or need a brief time-out from the intensity of some group exercises. In that space we have large pillows, blankets, stuffed animals and other soothing items. We use this for a number of reasons. One is to recognize the feelings of intense panic and overload patients with BPD can experience as they work to not automatically detach as a protective coping strategy. We want to support them using healthier coping and a way to stay with the group. Patients in the safety space are asked to return to the circle when they can and therapists check on them in a brief manner that does not disrupt the group’s work. The message is “We want to stay connected with you, you are important – we see you and it is OK to take care of your needs here.” We have found that this safety space can be an alternative to patients leaving the session, which is more disruptive to the group and has safety issues involved if they leave the clinic.

### *Therapist tool kit*

Some props are needed for the various experiential exercises we recommend. Table 5.2 gives a list of the things we like to have readily available when doing BPD groups. The reasons for some of the items will be clearer after Chapter 7, which describes experiential interventions by mode.

## **The Stages of Group Schema Therapy**

Young et al. (2003) describe three stages of ST for BPD: bonding and emotional regulation, mode change work and autonomy. There are four stages thought to naturally occur in the life of a therapy group: bonding and cohesiveness (forming), conflict (storming), establishing norms (norming),

**Table 5.2** Group therapist tool kit

<b>All purpose</b>	<b>Angry/Impulsive Child mode</b>
Whiteboard or flip chart	Towels for tug of war
Paper	Face cloths to tie up and pitch at objects
Pens, pencils	Clay, play-do
Construction paper	Stress balls
Magazines, collages	Larger balls to bounce against walls
Paints, brushes	Tennis racket to hit a mattress or couch
Tape recorder and tapes	Balloons to blow-up and pop
Ring binders for handouts	Bubble wrap to stomp on
Index cards	Phone books to tear up (in the US these tend to be a few inches thick, but a smaller one would do)
Stress balls	
Clay, play-do	
Ball of yarn	
Paint test strips	
<b>Abandoned, Vulnerable, Abused Child mode</b>	<b>Joyful, Happy Child mode</b>
Blankets	Crayons, colored pencils
Shawls	Coloring books
Stuffed animals	Puzzles
Paper tissues	Puppets
Children's books	Playing cards
Music—soothing	Games
Beads, stringing for bracelets	Balloons
	Happy music to dance to

The suggestions by mode are meant to provide ideas, not to limit using any tool for any mode. This is one of the places to be creative!

and the working group (Yalom & Leszcz, 2005). In GST therapists actively encourage the group stages that facilitate the goals of ST stages and actively manage those that conflict. The first and last stages of group therapy and ST are compatible; however, the conflict stage is not, particularly if it occurs before a BPD group is adequately connected. As described in Chapter 4, therapists must set limits on and empathically confront conflict in the early stages of GST. The third naturally occurring group stage – norming is replaced in large part by GST ground rules. Some negotiation of these is allowed outside of safety issues. The active therapist direction of GST condenses the first three group therapy stages into one and establishes the safety a BPD group requires to move into Stage 2 – Schema Mode Change work.

**Table 5.3** Relationship between Stages of groups and stages of GST

	<i>Stage 1</i>	<i>Stage 2</i>	<i>Stage 3</i>	<i>Stage 4</i>
Group Therapy	Forming	Storming- Conflict	Norming	Working group
	<i>Stage 1</i>		<i>Stage 2</i>	<i>Stage 3</i>
Group Schema Therapy	Bonding, cohesion Emotional regulation Safety, establish group family		Mode awareness Mode change work	Autonomy

Table 5.3 displays the relationship between group stages and GST stages. The autonomy stage in ST takes place as the Healthy Adult mode develops and becomes stronger. Early in this stage, therapists often must lead or lend patients some of their Healthy Adult. Later on it is important for therapists to step back and allow patients to try out their Healthy Adult skills. Judging which is needed can be challenging when also working to prevent too much nonproductive silence in sessions. We suggest sometimes saying something like, “Did I step in too fast there, was one of you going to respond to that?” In outpatient treatment the working group stage begins sometime between 6 and 9 months, but vacillates until about 12 months. The tapering schedule of year two is possible because we expect the group to be in its bonded stage and ready to begin the autonomy work of ST at that point. Obviously individual groups have their own course through these stages. In addition, the stages are not linear. Groups return to the bonding or conflict stages at times, particularly in response to crisis events in the group or difficult life events. We are describing here the general time frame we have observed over many groups.

The focus of a group or an individual session weaves back and forth among the modes the group presents. This could be within one session or over several. Chapter 9 provides an overview of the components, goals, and interventions of GST (Table 9.1) and a guide to the Patient Material Workbook is available on the Wiley website (Tables 9.2 and 9.3).

### *Anticipatory socialization for group therapy*

We prepare patients for group participation with two individual meetings to provide some socialization for the process of GST. We want to meet them

before group begins, if we have not been involved in their assessment, so that we have the opportunity to begin to connect with them and them with us. It is optimal to have both group therapists present in at least one of the two sessions. If you have the recommended “back-up” group therapist for times of vacation, illness, or unexpected absence, patients should also meet him or her. We use the metaphor of the extended family with “aunts” and “uncles” who step in when the group parents are not available. In these individual sessions we briefly go over their Schema Mode Inventory results and discuss why the group is being recommended for them. We need to have enough information about them to be able to describe for them what we think the benefits of group will be for them specifically. We want to have the opportunity to give them the information they need to make an informed commitment to the group based upon this information. We inquire about any previous experience with therapy groups, good or bad, and describe what the ST group is like and why it is likely to be a different experience. BPD patients can almost always give a number of examples of negative group experiences they have had. Usually they have been in mixed diagnosis groups from inpatient hospitalizations, sometimes outpatient mixed groups, and even BPD groups focused on skills. We want to instill hope about GST, so we describe how it helps people with similar problems, the promising results of ongoing research, and our own experiences. We describe why we think the group is a good choice for them. We give them the press release about ST outcome research which is available on the International Society Schema Therapy website [www.ISST-online.com](http://www.ISST-online.com) and REF 2. We validate their concerns, discuss any fears they have and try to give reassurance. We describe some of the struggles patients often have early in group due to mistrust/abuse schemas and rejection sensitivity, and let them know that we will work with those issues in the group. Warning them about having these feelings and that they pass over time helps them to understand what they mean and not to overreact to them by leaving group. We discuss their hopes about the group and tell them about the high approval rating we have from BPD patients and the very large positive effects from research. We go over the unique advantages for them of group treatment and invite discussion to accomplish “buy in.” If we are videotaping sessions, we explain the purposes (i.e., research, training, therapist review, their review) and obtain written consent.

What follows is an example of the way we approach issues like early discomfort and avoidance so common in people with BPD.

### Therapist script example: Education about group

“Group therapy is different from individual and there are some initial adjustments that the whole group needs to make. We need to get to know each other, figure out how we are going to work with each other, and deal with the uncomfortable feelings we all may have during this process. If your early experiences with groups, for example, family, school, or neighborhood, have been difficult, you could have the impulse, if the group at first also feels difficult, to leave it. This kind of avoidance as a way to cope with uncomfortable emotions is actually one of the unhealthy coping responses that we will be working with you to change because it keeps you stuck. So, if you have that reaction and bring it up in the group, we can talk about it and find healthy ways for you to feel more comfortable. What we have just described is one of the important opportunities that a group offers. With time and the help of the therapists, people come to feel that they have understanding, emotional support, and a sense of belonging that they always wanted but never had before. It is this kind of belonging that can fill some of the emptiness that you may experience. So, the group can become a kind of healthy family in which the child parts of you that did not have their normal, healthy needs met growing up, can have these needs for validation, acceptance, liking, etc., met and the little child in you can heal.”

Later we label some of the common experiences of people with BPD to facilitate a sense of commonality and belonging, the experience of universality that facilitates cohesiveness. At this point, however, we avoid saying “people with BPD” as it can be perceived as a negative evaluation or label. Until they know that we do not evaluate them negatively for their symptoms or problems and do not use the term “borderline” pejoratively, it is best to avoid the risk of this misunderstanding. Keep in mind that their mistrust/abuse schema, with its potential for distorting perceptions, also operates with therapists, despite our good intentions and view of ourselves as helpers. It is important to be mindful of our own schema activation (also known as countertransference) in response to their schema-related behavior directed at us.



*Ground rules and group commitment*

We provide ground rules in writing during the pre-group sessions (these are provided as REF 1). We tell potential group members that these ground rules have been created over time with input from other patients with BPD and we are open to their input as we work together. We acknowledge that if aspects of these ground rules do not work out for this group, they can be negotiated as long as they are not related to safety or confidentiality. It is explained that the ground rules are enforced by the therapists and that we understand that one of the problems they have is difficulty controlling anger and impulsivity. We do not expect them to be able to do this perfectly early in the group, so as an added precaution for all, in the unusual situation where a patient was not able to stop aggressive behavior toward others, they will be asked to temporarily leave the session to get the behavior under control. If a safety issue is involved, one of the therapists may leave briefly with the patient to arrange monitoring as needed. We also explain that they are expected to return and discuss the event with the group and allow us to make sure that they are safe. We stress that they will be an important part of the group and that we will do all we can to support them being able to stay in the group if they do their part. We tell them that we know that aggressive outbursts are often followed by the Punitive Parent mode beating up on the Vulnerable Child mode and we want to help them break that cycle by intervening at earlier points to help them with control. Having an angry outburst does not make them “bad” and following the ground rules and therapists directions, if this happens, is the way to be responsible to the group. We also tell them that the ground rules are designed to set up a safe, healing, predictable, nurturing, and validating therapeutic environment for all in which attention will be given to meeting everyone’s needs. We explain the “whys” to avoid them experiencing us as demanding or controlling parents. Of course, if we are perceived that way, it is an opportunity to look at the schema or mode triggering that is going on. This will be discussed in more detail later.

We explain that it takes about six sessions to begin to feel comfortable in any group and we stress the importance of not making a decision to leave during that period. We also make clear the seriousness of the commitment they are making to the group and we are making to them, as well as describe the negative effects on a group if people leave prematurely. We meet with them twice, in part to give them time to decide whether or not they can make a commitment in good faith and to think of any other questions or concerns that they have. As mentioned earlier, we want to make sure that they do not

anticipate a move out of the area or a change of job or lifestyle (marriage, birth of a child) that would interrupt their participation. Unforeseen events occur in life, but we have found it important to inquire about those that can be anticipated. About 80% of the patients we screen decide to join a group. In the first outpatient study we did we had zero drop-outs over the 14 months of the study. In inpatient pilots we had about 95% retention.

### *Limited reparenting*

Limited reparenting involves both specific strategies and a basic therapeutic stance. It is hypothesized to be one of the central active agents of change in ST and is a critical component that is present throughout the treatment. One of the similarities between individual ST and GST is the warm, safe, and nurturing atmosphere that the therapist is active in establishing. Young et al. (2003) describes the needed environment as one in which there is secure attachment, spontaneity and playfulness, realistic boundaries, and support for expression of needs and emotions, autonomy, and competency.

### *Education component*

The information provided in the anticipatory socialization sessions and in the early group sessions provides face validity for patients to collaborate and engage in the work of GST. Providing the information needed for collaboration is a part of the guidance function of limited reparenting. The content of the education component of GST is presented and discussed in Chapter 6.

### *Mode awareness interventions*

Mode awareness is a step that we added to ST interventions based upon our many years of work with BPD patients. It begins with a focus on emotional awareness. We realized that before we could work with patients collaboratively on change, they need to have words for their emotional experience and to be able to be aware of levels of emotion beyond the global 'all or none' that typically describes their level of emotional awareness. Many patients also have alexithymia and have difficulty assigning labels to emotions even when they are aware of them. We progressively help to expand their areas of emotional awareness and the ability to find words to express these feelings as part of developing an awareness of, and ability to talk about, modes. This component of treatment is elaborated in Chapter 6 on Stage 1 of GST.

### Main awareness interventions (with location)

- Level of Emotional Awareness Exercise (Chapter 6, pp. 15–16)
- Physical Grounding Exercises (Chapter 7, p. 11)
- Circle Monitoring (forms provided in AW 1-1, 1-2, 1-3)
- Mode monitoring (forms provided in AW 2-1, 2-2, 2-3, 2-4, 2-5, 3-1, 3-2)

Instructions for the interventions, patient information handouts, and homework are included in the Patient Materials Workbook.

### *Cognitive interventions*

Cognitive interventions appeal to reasoning and engage the thinking, rational part of patients in fighting their maladaptive schemas and recognizing schema modes. We usually start with cognitive work to build a verbal framework for later experiential work. Cognitive interventions are usually better tolerated, less anxiety producing, and more familiar to patients than experiential work. This is particularly true for BPD patients whose default mode is often the Detached Protector mode. It is important to create doubt about the core beliefs or cognitive components of schemas in order to motivate change. To patients, schemas are facts. They are usually unaware of how much early maladaptive schemas distort their view of the world, themselves, and other people. The notion is often new in the beginning of ST, unless a patient has been exposed to cognitive therapy. The cognitive component of schemas – core beliefs – is based upon early learning experiences. In people with severe personality disorders, these beliefs are extremely rigid and entrenched. It is a case of the “first thing learned” also being the “last thing learned” and part of the reason this group of patients are so stuck in their maladaptive patterns. The main cognitive techniques used in GST are listed here. They are described in Chapters 6 and 7, organized by mode.

### Main cognitive interventions

- Educational material on BPD, ST, Childhood Needs (ED ST sections 1–9)
- Pro and Con exercises (MCM 2, 3)

- Cognitive restructuring and reattribution (Chapter 7, p. 16)
- Flashcards (ACM 2)
- Cognitive distortions (MCM 4)
- Use of cognitive antidotes for schemas (COG 1)

Instructions for the interventions, patient information handouts, and homework are included in the Patient Materials Workbook (Education [ED], Cognitive Interventions [COG] and by mode).

### *Experiential interventions*

These interventions operate at the level of emotion and provide corrective emotional experiences. Young et al. (2003) describe this component of ST as “fighting schemas on the affective level.” These are the interventions that can change the felt aspect of schemas and modes. Patients often tell us “I know in my head that I am not worthless, but I *feel* bad and worthless.” Learning occurs more dramatically and faster in the presence of affect. Experiential interventions evoke affect. Groups are a particularly good venue for this work because of their augmenting effects on emotional experiences. We think this is due, in part, to group being a close analogue to the family of origin with all of its implicit associations and memories. Other experiential interventions involve the feelings of belonging and acceptance in a group, universality, the relationships with therapists and peers, and existential factors. The main experiential techniques of GST are listed here. They are described in Chapters 6 and 7, organized by mode.

### Main experiential Interventions

- Imagery (Safety Bubble EXP 9, Safe Place EXP 10, Good Parent EXP 3)
- Imagery rescripting (changing the endings of childhood memories EXP 5)
- Mode role-plays (Punitive Parent mode effigy, full Chair work, mode dialogues)
- Transitional objects (developing and using, Identity Bracelet, Vulnerable Child mode Treasure Box) (Chapter 7, pp. 41–43)

- Creative representations of group experiences (scents, drawings, collages, etc.)
- Play (Chapter 7, pp. 43–46)

Instructions for the interventions, information handouts, and homework are included in the Patient Materials Workbook, primarily section EXP.

### *Behavioral pattern breaking interventions*

Behavioral pattern breaking is an important component of change. Behavioral change starts in psychotherapy sessions then moves to the patient's world outside of therapy. An advantage we have in the group is its capacity to be a microcosm of the real world. The group can be a safer place for patients to try out new healthier coping strategies, risk being vulnerable, practice new behaviors, and receive constructive feedback. The behavioral pattern breaking stage of treatment in ST is the point at which the patient is able to choose healthier coping strategies instead of their former schema-driven behaviors. It is important during this stage to continue to collect evidence about the improved outcome of these new strategies and to practice and fine tune them to maximize the likelihood that they will lead to the person's needs being met.

### Main behavioral pattern breaking interventions

- Emergency Plans (BEH 1-1, 1-2)
- Mode Management Plans (BEH 2, 3, 4)
- Evidence logs (BEH ANT 1, 2, 3, 6)
- Role-play practice (BEH ANT 4, 5)

Instructions for the interventions, information handouts, and homework are included in the Patient Materials Workbook, primarily in the BEH section.

### *Interpersonal interventions*

The group itself is an important source of interpersonal learning, offering modeling and opportunities for vicarious learning. Our patients frequently

have told us that it took watching an Angry Child mode tantrum in a peer for them to truly understand the effect of that behavior in themselves on others and to be motivated to change. The ST group functions as a supportive family and is usually the first time a patient with BPD has experienced this. We first learn about ourselves from the reactions of others and the labels they apply to us. The group is a place to have early misinformation corrected. The comments and new positive labels from peers can be powerfully challenging to the defectiveness/shame schema. The experience of acceptance in the group has tremendous therapeutic value at the emotional level for the Vulnerable Child mode. Group is a place to practice forming and maintaining healthier relationships, explore boundaries, develop communication skills, and learn how to negotiate and resolve conflict when needs are at odds. Because the impairment found in personality disorders has such a large interpersonal component, one might argue that a setting rich in interpersonal interactions is especially well suited to provide the required corrective emotional experiences.

### **Integration of the Awareness-Focused, Cognitive, Experiential, Behavioral, and Interpersonal Components of Group Therapy**

We speculate that the large treatment effect sizes ST demonstrates for BPD patients are due, in part, to the model's integrative approach to deeper level personality change; one that includes awareness, cognitive, experiential, behavioral, and relational techniques. ST includes interventions of all these types to accomplish long-lasting change. ST is the only truly integrative approach to personality disorder treatment. Other approaches are weighted toward either cognitive, experiential, behavioral, or interpersonal to the neglect of the other components. This may also account for the high rates of recovery being found with ST for BPD and, in particular, for the group approach. Chapters 7 and 8 present in detail the group adaptations of ST interventions by the schema mode they target.

#### *The order of activities within the session*

*Beginning sessions* We start sessions in the same way throughout the life of the group – with a safety image. The particular safety image we use changes over time. In early sessions we use the image of a “Safety Bubble” around each individual and around the whole group. Using therapist-provided safety images early in the group's life can speed up the feeling of some

amount of safety. If you begin by asking patients to work on a “Safe Place” image, inevitably one or more will tell you they “have never felt safe” and “cannot possibly do that” and will feel either growing agitation, anger, or a sense of failure. We came to use the image of a “Bubble” after our lack of success with asking patients to come up with their own image and failed attempts to use some of the basic beach or nature scenes useful with other patient groups. When we chose more specific images for the group there would always be people who had had some traumatic experience in the place we chose. Since we are just trying to help make the environment safer, we wanted something that would work, not something complicated to have to reframe, discuss at length, or deal with in a flashback. Later on we help patients develop an individual “Safe Place” and reassuring “Good Parent” images. We also stress that the group therapists will keep the group safe. Along with their imagining a safe place, we regularly let them know the group is, and will remain, a safe place and that we, as the therapists, will make sure of it. In early sessions we check on patients who seem to be distressed or say they are in a Vulnerable Child mode.

In year two we usually give a more open beginning image that allows patients to use the image that fits best for them on that day. Beginning this way helps to speed up the feeling of some amount of safety in the group. Again, we stress that the group therapists will keep the group safe. We add suggestions to the image, expanding on the notion of the group being a safe place and adding other “Good Parent” messages. More structure and direct therapist intervention is needed in the beginning of treatment. Safety images begin with the therapist providing external support like a safety bubble around the whole group or even individual bubbles for patients who do not yet feel comfortable enough to join the group. As time goes on, safety images progress from a patient being in the bubble with the group, personal safe place images, the therapist stepping into the image as a good Protective Parent, the therapist inviting the patient’s Healthy Adult to join hands with him/her and ultimately the Healthy Adult of the group and the individual patients being the source of protection and safety.

### Example

Some of our good parent messages are: “We are glad that you are here with us. We think that you are in the right place to get help. We know

it can be difficult to start something new and respect your courage in doing this. Good for you. We know you can do it. This is your opportunity to really change your life. ST may be one of the hardest things you have done, but it is also a therapy that can make the biggest positive difference in your life.”

### Example: Safety for the Vulnerable Child

In early sessions, when a patient is in the Vulnerable Child mode, we ask him/her what he/she needs and make sure his/her need for safety is met. The latter can be accomplished through something as simple as the suggestion to move his/her seat, hold a pillow, or wrap in a shawl. In a later session, if a patient ends up in Vulnerable Child mode after our introductory safety image, we may take advantage of the opportunity this presents by doing some experiential work with the Vulnerable Child mode. If we do this, we make sure we tie the whole group into it. This could take the form of some imagery rescripting related to the patient in Vulnerable Child mode experiencing the therapist coming into the image and being actively protective.

Regarding the “Good Parent” example, we will make comments based upon what we observe in the patient early in the group. Over time we want to help patients move from nonverbal expressions of needs to putting their needs into words and taking healthy action to get them met (e.g., move to a safer seat in group).

### Example

In the working group phase we may just ask patients to connect with their Safe Place image, say a few general “Good Parent” messages like “we are glad that you are all here. It is great that you all have developed a safe place to use now, something that you did not have in childhood” and go on to planned work.



*Early middle working period* The next step in early groups could be a short discussion of the homework assignment – what they learned, the feelings it may have stirred up or modes triggered or what was difficult. In later stages, we just refer to the assignment and move from it to new experiential work such as imagery rescripting. In advanced stages we may just collect the homework, and then it is important to look it over and write some encouraging comment about their work to shape it and validate their effort.

### Example: In session use of homework

In the homework from the prior session, we asked for two examples of times they were aware of a coping mode. We might go around the group asking each patient to read just one example. We use the “go round” approach to who goes next unless the patients strongly object. We do this for two reasons: first, it saves the time that it will otherwise take for us to wait to see who volunteers to go next and, second, it removes some of the patients’ anxiety about when to speak. BPD patients usually like this system. Ida suggests that it helps ensure that she remembers to hear from everyone.

Later (around 3–4 months) we might ask them to get out their homework to refer to and go right into an experiential exercise that they will use some of the homework information for.

### Example: Using homework as a bridge

“We asked you to think about what you would have liked to hear from your parent as a child and to write it down. Let’s go around and have everyone tell us one of the statements you wrote down that is especially important to you. I will write it down so that we can make a “Good Parent” script that Ida and I are going to read to you.”

In early sessions there is a **brief didactic discussion** on the task or content area that is part of the first 6 or 12 weeks agenda. We make this as interactive as possible to avoid boredom leading to detaching. This can be as simple as

asking for a show of hands as to whether anyone has ever had the experience we are presenting. If it is something previously discussed, we may bring them in by remembering that “I recall that Suzie, Karen, and Jane said they experience rapid mood swings they don’t see coming.” In advanced sessions (9–24 months) the agenda is more flexible and based upon the mode present in the majority of group members or a mode that is affecting the group in some way.

*Late middle working period* Next, we go to an experiential exercise, mode role-play, or cognitive exercise based upon the mode of focus for that session. This is followed by processing and/or debriefing from the exercise and discussion about how it applies to the various group members. We make sure that every group member is included in this discussion and the effects on them identified, referencing either individuals or subgroups.

It is essential for the therapist to balance experiential work with the cognitive processing of awareness and insights that occur in the course of the experience. This is a defining aspect of ST whichever modality is being used – individual or group. As schema therapists we know that “feeling something in your gut” and “knowing it in your head” are both essential to therapeutic change.

*Wrap-up and “homework”* We often wrap up sessions by asking patients what they will take away with them from the session; give them a written handout of material to read for next week or a homework form. Handouts to take home and assigning homework serve a number of important purposes. One purpose is to provide predictability that increases feelings of security and reduces anxiety in a population that struggles with mistrust and abuse. There is also a basic communication of respect and validation of their competence that comes from giving patients information and approaching them in a collaborative way rather than being “experts” who “know it all” but share little. Also telling them what you are going to do is a way to include them in it. Homework fosters connections among members and fosters group cohesiveness. They know that other members have also been thinking about and working on the same assignment during the week. We use homework in a flexible way. Completing it is not the only acceptable response. For example, it counts if you “thought about it” or became aware of a barrier to completing the assignment (e.g., the topic triggered the Detached Protector mode or another mode). This approach to assignments is very important as a way to encourage patients with failure and defectiveness/

shame schemas to take the risk of trying. If not attempting homework is a repeated issue, it can be discussed in a general way without singling anyone out. Discussing it in a supportive manner in the group is helpful as peers may have ideas from their experience about what the difficulty is and what some solutions might be. The experience of receiving help from the therapists and the group when they are having a problem is an effective antidote to the mistrust/abuse schema and criticism from the Punitive Parent mode. This is an example of using the process and experiences that are possible in a group as well as the content.

*Ending sessions* We end with either a safe-place or individual safety-bubble exercise. This has the dual purpose of wrapping things up and increasing the likelihood of patients being in a Healthy Adult mode when they leave. We may also suggest that they leave difficult topics or issues in the group space. In early sessions, when the patients may be starting to thaw emotionally or come out of detachment but still have limited emotional regulation and distress tolerance skills, we need to actively help them with that process. During the imagery exercise, we add “good parent” messages based upon the current themes in the group. These could consist of things like “Remember that you are valued here and that you belong.” or “Take as much as of the warmth and support you received here today as possible and practice recalling it during the week to really make it yours.” We do this with the aim of increasing what is internalized in the reparenting process.

The chart in Table 5.4 shows a way to think about timing over the course of a group session and how this changes over the life of the group. The chart refers to weeks so that it can cover most outpatient formats we use – twice weekly group and weekly group plus weekly individual sessions. It is based upon having about 45 sessions a year, allowing for holiday periods. Again, the time frame given is approximate and the journey of each individual group to the ultimate goal of recovery and autonomy will be its own.

This chart is meant as a rough guide for timing various therapeutic interventions in the group session, not as a strict protocol to follow. We have found that time management can be a challenge for therapists when dealing with a group of patients with a variety of needs, especially when they are new to this work. We meet this challenge by paying attention to these five time frames. However, wherever you are in the session and whatever the stage of group development, flexibility on the part of the therapists is critical in ST whether it is the individual or group modality. We usually share our session agenda with our patients as another way to

**Table 5.4** Session timing guide for Year one

<i>Time in session</i>	<i>Session number</i>	<i>Activity</i>
Beginning of session	1–12	Address safety, use Safety Bubble or other safety image Describe agenda Brief mode check in after ST language is learned
	13–24	Personal Safe Place image or, Good Parent image Mode check in
	25–36	Mode check in Brief safety image that fits the current work being done in imagery “as needed” or suggestion to connect with personal Safe Place based upon modes identified in the check in
	37–45	Mode check in Suggestion that those who need to, connect with Safe Place image as you go to experiential work with the modes present with less direct therapist leading
Early working period	1–10	Homework discussion – weave in mode identification New didactic material (early stage cognitive work)
	11–23	Sometimes homework discussion, may just collect depending upon assignment, patients’ reactions and modes present Brief didactic review of topic material as needed Cognitive schema change work – e.g., Detached Protector pro and con list Experiential work like parent effigies, Angry Child work, etc. Beginning of rescripting by rewriting memories
	24–36	Imagery re-scripting or Mode Role play
	37– 45	Imagery re-scripting or mode role-play for deeper trauma
Middle working period	1–10	Exercises to increase mode awareness Group as a whole imagery work see Vulnerable Child, therapist as Good Parent Mode role-plays based on present – option of patient as observer to use vicarious learning option in group soothing exercises, e.g., music

*(Continued)*

**Table 5.4** (*Continued*)

<i>Time in session</i>	<i>Session number</i>	<i>Activity</i>
	11–23	Exercises to replace coping modes with safety/grounding/etc. Imagery work – Good Parent Mode role-plays with more involvement of protagonists – e.g., banish Punitive Parent
	24–36	Brief cognitive processing – more time for experiential work
	37–80	Brief cognitive processing – more experiential work Review behavioral pattern breaking work in group and outside
Wrap-up	1–10	Cognitive processing and/or work to label or anchor experiential work done in session Homework – with awareness focus
	11–23	Cognitive processing and/or work to anchor experiential work done in session Homework expanding mode awareness to the effect on others and reactions elicited by coping modes, whether needs are met
	24–36	Cognitive processing and/or work to anchor experiential work done in session Homework with mode management focus
	37–45	Homework with behavior change focus
Ending of session	1–10	Safety Bubble, group room as it becomes safe – insert therapist as Good Parent, group added as it becomes cohesive as a safe family
	11–23	Patient's personal Safe Place image – linking Vulnerable Child with therapist, group's Healthy Adult – e.g., "We are also a circle of strong Healthy Adults to protect Vulnerable Child Later add focus with their Healthy Adult
	24–36	Image linking Vulnerable Child and their Healthy Adult
	37–48	Healthy Adult strengthening image, reminder to care for Vulnerable Child needs

establish predictability and security. We have found that it is supportive and comforting to BPD patients to know, in general, what to expect in the group session. This is not surprising given their common experiences of lack of predictability and the effects of the mistrust/abuse schema most of them have. Information, in general, is usually reassuring. They usually deal with even disappointing information better than being left with no information. In the latter situation, their negative attentional bias fills in the blanks with a possibility that is invariably much worse than reality, so we don't want to leave them guessing.

*“Seize the moment” – opportunity work in GST*

There are two basic types of schema mode change work that occur in the group: “opportunity work” that comes out of the interpersonal process of the group and the modes patients are in and “planned or scheduled work” that is introduced by the therapists via exercises and homework. We have been describing the planned work of early group sessions so far in this chapter. Here we begin discussing opportunity work, which presents a different kind of challenge for psychotherapists. The ability to lead both types of work is an important competence in GST. Cognitive or behavioral work can be set up, put aside, and returned to fairly easily. Experiential “moments” in sessions cannot be made to happen; we can only set the stage for them. We cannot predict exactly what emotions will be triggered by experiential exercises, so if emotions or a mode (e.g. Vulnerable Child mode) that we want to facilitate occur – we seize them. A rule of thumb here is, if a patient is in the Vulnerable Child mode use it as an opportunity for a reparenting intervention as healing the Vulnerable Child mode is central to ST. The example of Karen in Chapter 7 illustrates how an unanticipated negative response, in this case to the Good Parent Script exercise, led to a breakthrough in her experiencing that she was not to blame for her stepfather's sexual abuse of her. We were expecting the more common positive response to the exercise, but the group as a whole was very pleased with the outcome in terms of Karen. It also prompted a number of other patients with similar histories to think about how valid it was to blame the child for an adult abusing her/him.

It is important to go into any session with a *goal* in mind which is hopefully an interaction between ST theory of change and your particular group. We also suggest in year one going in with a plan, with the caveat of being willing to set the plan aside to take advantage of opportunities for experiential

work related to your goal. This does not mean go with “whatever comes up,” rather to strategically focus on opportunities relevant to the goals of ST, the stage your group is in, and their needs. Meeting our patients where they are emotionally and responding at this level is central to reparenting. By doing so we let them know that their emotions are important and need attention. Our response is in direct contrast to their childhood experience of having their feelings ignored or punished. We tell them that we value and want to know their emotions so that must be evident in the way we interact with them. This approach is quite different from the skills focus of CBT or DBT. Frequently the work that is accomplished when we “seize an experiential moment” ends up having more impact than what we planned because it is a better match with where the group is on an emotional level.

We have found that it important to explain this way of working to the group members to prevent their Demanding or Punitive Parent modes from beating them (or us) up about not following the agenda or taking the group off track. Patient’s parent modes (and even those of the therapist) may criticize the therapists for “getting off track,” “not leading properly,” or “not being in control” if they are not told that going back and forth between what comes up emotionally in the group and planned work is what is “supposed to be” happening. We also find in supervision that it can be difficult for therapists not to feel that they have somehow “failed” if they do not complete the planned task for that session. We try to make the point that abandoning a session plan can be fulfilling the goal. Keeping a balance between seizing opportunities for experiential work and balancing it with cognitive processing of the awareness and insight that result from an experience is an ongoing therapist task. This is a defining aspect of ST whichever modality is being used – individual or group.

Given the magnitude and complexity of the group therapy task, going in with a plan, even if you discard or adapt it, can feel reassuring to the therapist. Joan always has a goal and a plan which she develops based upon the preceding group sessions. She says that she probably uses her plan about 50% of the time but stays with her goal about 90% of the time. It is important to keep the difference between the two in mind. It is important to remember that *the* course of psychotherapy is not linear – it dips and soars and frequently curves in beautiful and unpredictable ways. As long as you are following the overarching goals of ST you are on the right track. Flexibility is critical in individual ST and is, arguably, even more so in GST because of the wider range of modes that need to be matched or the amplified intensity of a number of patients in a mode that cannot

be ignored (e.g., the emotional impact of a number of patients in Angry Child mode when you had planned to do Vulnerable Child mode work). Prioritizing “opportunity” or process work is one major difference between GST and other CBT or DBT groups that are much more structured and focused on teaching skills and less interested in the process of the group and individualization.



# The Course of Group Schema Therapy Stage One: Bonding and Emotional Regulation

J. M. Farrell and I. A. Shaw

Stage One of Group Schema Therapy (GST) consists of bonding, cohesiveness, and emotional regulation. This stage coincides with the forming, storming and norming in the life of a group. It prepares the way for the mode change work that corresponds to the working group stage. We have added cohesiveness to the bonding stage of individual ST to reflect this added therapeutic factor of GST. We include in this stage, education about what to expect in a therapy group, about Borderline Personality Disorder (BPD), and the Schema Therapy model to prepare patients to be active collaborators in their treatment. This collaborative approach facilitates bonding. We also speculate that the group of patients being “students” together, engaged in the therapeutic process of learning about themselves, adds to group cohesiveness. Bonding and secure attachment are viewed in many approaches to psychotherapy, including ST, as necessary for **emotional regulation**. We have added **emotional awareness** work and **safety imagery** to fill what we see as additional gaps in the emotional development and regulation ability of patients with BPD. Awareness of modes being triggered and operating is important to Stage Two of GST – mode change work. Safety images and emergency plans that address life-threatening behavior are stopgap measures to ensure safety at the beginning of treatment for BPD patients.

## **Bonding and Cohesiveness**

**Bonding and cohesiveness** begin with limited reparenting interventions to form a healthy group “family” (discussed in Chapter 4). The process of education is conducted in a manner that continues the group’s bonding and introduces the therapeutic factor of universality. A sense of belonging in the group comes initially from patients’ discovery that they share a diagnosis, common problems, and many life experiences. Subsequently, they discover additional shared experiences in their developmental histories. The universality that is established by the therapist pointing out these commonalities is the basis for their initial bonding with each other. Schema chemistry will be present as well, drawing some patients together and some patients with a therapist. In the long term, this basis for connection may be positive or negative, but it can be examined later in terms of schema modes and can provide opportunities for understanding relationships. As the group develops additional connections are established as emotional experiences are shared and a shared history develops. As therapist-“parents” we are attempting to weave our little family together in an ongoing way through their connections with us. This can be as simple as sharing something of mutual interest with the group, or pointing out interests or experiences that patients share (e.g., a new art exhibit, a book, movie, or something that cannot be perceived as confidential information). There are many levels of this approach. As the group develops, we will also point out, with their permission, emotional and even trauma experiences that they have in common. We talk about the group as an entity and use experiential exercises to facilitate connection. One example is the “Connecting Web exercise.”

### **The Connecting Web Exercise**

Patients and therapists toss a ball of yarn back and forth, holding on to it each time it comes to them so that a web of connections is constructed within the group circle. We suggest that each person makes eye contact before they throw it to another.

- This is first used solely as a **connection exercise**. We say to patients, “Be aware of all the connections we have in the group, feel the

strength of them, and take a mental or real snapshot that you can later bring to mind to remember your place in the group. Look at all the connections and see how we are all linked together. Every one of you has an important role in the group. You matter and are needed to make our group strong.”

- Variation 1: give each patient a piece of the yarn to take with them to represent the group connection. Psychotherapists in the Netherlands modified this to have patients tie the yarn around their wrists like a bracelet. They told their patients about the custom in Asia of having a string from the temple and wearing it as a bracelet until it fell off. That group liked the idea and added that when it wore off they would do the exercise again to have a new piece and renew the connection. These patients expressed shock at the next session when they saw that their therapists were still wearing the group string-bracelets. They were surprised that the group meant enough to the therapists for them to keep the strings on. This suggests that the bracelet exercise can also strengthen or deepen the group’s feelings of connection with the therapists.
- Variation 2: give each patient a glass bead that represents the group to place on the string and have the person sitting next to you in the circle tie the bracelet with bead onto your wrist. This variation is followed up with additional beads for various other group experiences or events. For example, a bead to represent your safe place, to remember your little vulnerable child, etc.
- We have worked with art therapists who had their groups paint the connecting web; making drawings, taking photos, or moving the web literally into paint and then moving it onto huge paper to have a quite literal representation.

### *Education*

We give patients a written copy of the educational material we use and a three-ring binder to keep a therapy notebook. This ensures that they have accurate information to refer back to in case their distress level in early sessions is high and interferes with attention and concentration. We ask them to bring their therapy notebooks to each session, as we refer back to various handouts and continue to add to it with exercises, handouts, and homework. The therapy binder constructed for each group will be unique and comes

from the patient workbook materials that are available online and described in Chapter 9. We have found that patients keep these notebooks for years and refer back to them. They often take them to individual therapists not using ST to describe what is helping them. They say that they are “teaching” their therapists about what they need. The notebook can also function as a transitional object; a tangible representation of the work they have done and of the group/“family” that they take with them into the autonomy stage and beyond.

### *Information about group therapy*

We begin giving patients information about GST in our individual sessions with them before the group starts and go into the topic further in early group sessions. We refer back to the research that suggests augmenting & catalyzing effects for GST (Farrell et al., 2009; Dickhaut & Arntz, 2010; Fassbinder et al., 2011).

### Information about how GST works

- We tell them how critical their role is to the group’s success and that they are all important to us and to the group. We tell them that we care about all of them and want them to be part of the group “family.”
- We tell them what patients with the same problems have said about the group experience; that they have a sense of belonging, feeling understood and accepted, and “there are people like me” for the first time. We add that these positive feelings may take time to develop and that initial negative reactions may be a result of protective coping modes.
- We remind them of the ground rules in a supportive manner and tell them that we will support them being able to follow the rules for the sake of a positive group environment.
- We describe the ST concept of limited reparenting and the role of the therapists in keeping everyone safe, setting limits when needed, and preventing any verbal attacks or aggression.
- We describe the therapists’ role in group and that we are sometimes like the conductor of an orchestra and at others like a referee.

- We stress the importance of their commitment to and respect for the group and other members (e.g., confidentiality, being on time, not interrupting, no name calling, good communication basics).

### *Education about BPD*

We want patients to have accurate and up-to-date information about what is known about BPD, and why they have been given that diagnosis. We provide this education in non-pejorative terms, beginning with how the diagnosis is made. For this we use the symptoms as described in the *Diagnostic and Statistical Manual of Mental Disorders*, DSM-IV TR. As DSM-V becomes widely used, we anticipate switching to that set of symptoms. As we describe in Chapter 5, we go through the symptoms of BPD and ask patients to indicate which they experience by a raise of hands. Inevitably all, or nearly all, raise hands for five or more criteria. This is the beginning of group bonding and feelings of belonging that can pierce through the Detached Protector mode and reach the Vulnerable Child mode. It is also the beginning of some trust that we therapists might actually understand them.

We discuss BPD etiology in terms of ST theory and the origins of BPD schema modes in unmet childhood and adolescent needs and experiences of trauma. Group members discover similarities in their growing-up experiences, including sexual, physical, and/or emotional abuse or deprivation. They connect over abandonment experiences due to parental death, divorce, or the inability of a dysfunctional parent to meet normal childhood needs. Sometimes adoption is also experienced as abandonment by the biological parents. We provide basic information about the neurobiology, how temperament interacts with environment to produce impairments in attachment, limits, sense of self, interpersonal relationships, and impulsivity. Engaging patients in these rather intellectual discussions can appeal to the often underused and undervalued intellectual aspect of their Healthy Adult Modes, which we want to strengthen. We discuss and empathize with their common experiences of stigma for being deemed “borderline” within their families and even within the mental health care system. The emotional validation and compassion expressed by the group therapists toward the experience of the patients as innocent children assists further bonding with the therapists. Discussion of these shared experiences fosters cohesiveness and further group bonding. Bonding and cohesiveness provide hope and motivation for treatment.

This information should be conducted in an interactive format, applying it to group members as you go and pointing out commonalities and differences.

### Education about BPD

- A way to understand yourself
- The diagnosis and symptoms (ED BPD-1)
- Discuss BPD criteria: their experience of the different symptoms of BPD (EDBPD-2)
- Why BPD? – the developmental model that is consistent with ST, along with information about how temperament and early environment combine to form schemas
- Empirical evidence that schema therapy treatment leads to recovery from BPD and improved quality of life

This information provides patients with cognitive restructuring for the way they think about their history and current experiences (i.e., “I have a legitimate disorder. I am not just bad”). We give patients handouts with this information for their therapy binders and to share, if they like, with interested friends and family.

An excerpt from the homework assignments that lists BPD symptoms arranged by Behavior, Affect, Interpersonal, Self and Reality Orientation with questions about their qualifying behaviors and emotions follows (full form in ED BPD-2).

### Emotion – list your experiences

- Reactivity – quick and/or frequent mood changes or intense reactions
- Anger – difficulty controlling anger, intense anger

We keep the amount of their self-disclosure at a level that matches this early session by asking patients to indicate whether they experience a problem in that area or not by a raise of hands.

### Therapist Tip

Pull the group into the discussion whenever possible. One way to accomplish that is to refer back to information individuals have given as examples of each criteria and mode. Refer to how many of them raised their hands, underline what they share (remember it is okay to have differences too). Use the education process to foster beginnings of cohesiveness. We give education in group rather than individually as it is such a good way to demonstrate how much they share underneath superficial differences like age, education, and marital status.

### *Information about the Schema Therapy model*

Most patients are able to understand and learn the user friendly language of ST fairly quickly. The model gives them words to describe their experience and explanations for it that are non-pejorative. Sometimes interference from their defectiveness and failure schemas creates anxiety about “getting it right,” which slows them down or even shuts them down with the Detached Protector mode. It is important to give them reassurance that they are not “stupid,” that they are just learning and we all make mistakes as “learners.” This fact is usually alien to them and a helpful concept to use later on in fighting the Dysfunctional Parent modes. When there are patient mentors in the group, they can share their struggle with the learning process, adding further evidence that this is normal. We give them ST summary handouts to keep handy for reference and we include ST terms with definitions on their homework forms for reference and as another exposure to the terminology (ED ST-1 to 11). We have found that patients begin talking in “my modes” terms very quickly after being introduced to the language of ST. The language eventually takes on the quality of “family language” for the group and adds to cohesiveness.

### Education about the Schema Therapy model

- Childhood needs and healthy child development (ED ST-5)
- The ST model of how BPD develops (ED ST-4, 11)

- Information about schemas (we limit this information to schemas of high significance for BPD and to their role as the triggers of modes)
- Schema modes and how they affect adult life (ED ST-1)

*Childhood needs and healthy childhood development* We give patients this list of core childhood needs with questions about their experience of them being met or not in childhood and today.

### List of childhood needs

- Secure attachment to others (includes safety, stability, nurturance, and acceptance)
- Autonomy, competence and sense of identity
- Freedom to express valid needs and emotions
- Spontaneity and play
- Realistic limits and self-control

We ask two questions for each need listed:

1. How was this need met (or not met) in your childhood? By whom?
2. How are you aware of each need today and how is it met?

Not surprisingly, we discover that most of our patients' needs were not met in childhood and are not met in their adult life either. We learned in our first BPD group that the word "need" in and of itself creates a lot of anxiety for this patient group. We came to understand that this was related to the Punitive Parent mode and what they learned about their needs growing up. The general answer we get is a version of "needs are bad," "I am bad to have needs," or "I am too needy." We spend time discussing the basic needs of all children; with emphasis on the *all* since our patients rarely assume that they are in the same category as other children. We provide reading material on childhood development and use homework and group exercises that ask if and how the list of basic needs were met and what they learned growing up about their needs. The general discussion of childhood needs lays the



groundwork for later sessions when the group is at the stage to do imagery change work for the Vulnerable Child mode.

In group sessions, the sharing of these difficult childhood experiences is done in brief segments. In this way, over time, patients' "stories" are shared. This group-focused approach to sharing information is in contrast to individual psychotherapy where a block of time is dedicated to one individual. It is also different from the person-centered group model in which the same is done. On some occasions, one member may strongly want to share more of his/her story. If their story is not too detailed regarding abuse and it can be used to make the important basic point that "children are never to blame for abuse", we might let it go on. The example of Ann met all three criteria.

### Example

Ann told the group about her experience of not being protected as a child. "My aunts, uncles, and cousins came over every Sunday and we kids were sent to the basement to play while the adults were upstairs drinking. I have older male cousins who made us "play doctor" and later made me touch them and touched me. I didn't like it, but I was more afraid to go upstairs to the adults. We were never checked on and got the message that we were on our own and not to disturb the adults. I started saying I did not want to go over there, but my parents told me I was "part of the family even though I was adopted" and I had to. My cousins said I better not tell now as I had let it go on too long and so it was my fault too. I had problems in school and was sent to a counselor at 11 years old. I told him and he said it was not normal and it meant that we were bad kids, that I was bad too or it wouldn't have happened. So, I never told anyone again until now."

This example illustrates the level of detail and length we judge a group generally able to deal with therapeutically. Ann's group was very supportive of her and outraged by the counselor's remarks. This was the beginning of her questioning the central evidence that her defectiveness schema was based upon. In these early group sessions we are balancing two goals: patients sharing personal information to facilitate group cohesiveness and the experience of universality, and limiting the amount of re-experiencing of

traumatic events that both the patient reporting the experience and those listening might feel. We try to avoid patients feeling overwhelmed with negative affect early in group, at a time when their emotional regulation skills are weak. In general, we limit the detail of abuse experiences, instead focusing on the feelings and needs of the child in that situation. We are sensitive to not wanting the patient to feel cut off or that some criticism is implied by our shaping of what they share. It is possible to gently limit the detail patients share by explaining that we do not want them to have the distress of reliving these experiences. To us this approach is an example of “being a good parent” – in this situation by being protective. Revisiting the trauma is not the way the Vulnerable Child mode heals. We want to help them rewrite the endings, so that their Vulnerable Child mode is protected and rescued *before* “something bad” happens. It is reassuring for patients to hear this and have reminders of it when we begin imagery change work. If a patient expresses the need to share more details than fit the group structure, we would suggest individual sessions to meet that need.

### Therapist Tip

Patients may be reluctant at first to share content verbally, but they may nod (often only a very little bit, so be observant) in response to something, or if you ask everyone who has experienced fears around abandonment to raise their hand. Refer to any of these indications when discussing the material to make it as interactive as possible. Try to remember the specifics for each patient as this both conveys interest and helps them feel included in the group. Point out both commonalities in their experience and individual differences, as you want to model that both similarities and differences exist among group members.

**Don’t worry in these early sessions about pushing to get the task finished.** The over-riding task is establishing safety and facilitating bonding and cohesiveness in the group. Content tasks are a lower priority. You will get to the content of the sessions eventually. Developing the safe, caring environment is top priority. Actually, one important reason for providing information is that it can facilitate bonding if it is presented in the manner that is described here. Keep in mind: **match the modes of your group. If you do that, you are doing a “good job”.**

*The Schema Therapy model*

We move from this foundation work on childhood needs to the ST model for BPD etiology. We give patients the visual model in Figure 2.1 (EDST-11). The ST model provides face validity for our work to help patients understand the role of childhood experience and temperament in developing BPD symptoms. It is an introduction also to schema and mode concepts and the “big picture” of ST. We share this information to facilitate active collaboration, which is consistent with the recovery philosophy of ST.

We provide patients with handouts on schemas and modes and suggest that they keep them available for reference. Included here are some excerpts.

**Patient handout: ST Model**

**Modes** are the moment-to-moment emotional states and coping responses that we experience. Problem modes are triggered by life situations that we are very sensitive to because of our past experiences – our “emotional buttons.” The most extreme modes are dissociation and brief psychotic episodes. The least extreme problematic mode is, for example, a lonely mood or angry mood. We refer to modes as “parts” of us, and all of us have different parts or aspects of ourselves. We do not mean “parts” in the sense of dissociative identity disorder, although people do sometimes have amnesia for parts of themselves that they have difficulty accepting or when the emotion is extremely intense. Some modes may be set off frequently, others very infrequently. They can be dormant for years, and then set off by a major life situation – for example, divorce, birth, death. The more we understand them, the more we understand ourselves and can take the actions needed to have a healthy, happy, and fulfilling life. People who suffer from BPD tend to have more disconnected parts and to flip between modes, which accounts for the quick mood swings and emotional reactivity our patients often experience. The goal of ST is to reduce unhealthy modes and strengthen the healthy ones.

*Understanding Schema Therapy: modes, needs, and BPD*

Patients need to understand the relationship between unmet childhood needs and the formation of modes. They also need to understand what happens when modes are triggered and how modes are related to BPD and the problems they are experiencing. This understanding allows cognitive restructuring that reduces the self-blame and shame patients feel. This is an important step in the process of the Vulnerable Child mode healing. This involves, among other things, defectiveness/shame schemas changing and self-understanding and acceptance increasing. The “Mode Origins” exercise that we do in group is an example of the approach used in GST to foster self-understanding. We use the same raised hand technique that we did with BPD symptoms to continue to build cohesiveness and attempt to reduce anxiety in these early sessions.

**Mode origins: understanding how your modes developed  
(ED ST-4)**

The VULNERABLE CHILD MODE holds intense painful and frightened feelings from childhood experiences in which your core needs were not met. These feelings were unbearable, even threatening to your survival as a child so they triggered the fight, flight or freeze emergency responses that are “hard-wired” in our brain. Now when something happens that is perceived as like those early experiences, like a core need not being met today, the brain reacts with its defense system as if you are back in time and your survival is again being threatened. You can see in your mode definitions sheet that the old unhealthy Coping modes correspond to fight (overcompensation), flight (avoidance) and freeze (surrender).

Understanding how various feelings and needs were responded to when you were a child can increase your understanding of your “little child” part (aka the Vulnerable Child mode) and his/her needs. Hopefully, you will also feel some compassion for the young part of you who had to experience all of this alone.

**FILL IN THE NEED BLANK** WITH ONE OF THESE: protection, validation, feeling loved, comfort.

**FILL IN THE FELT BLANK** WITH ONE OF THESE FEELINGS: fear or anxiety, sadness or hurt feelings, and then describe how your parents responded.

1. When I needed \_\_\_\_\_ because I felt \_\_\_\_\_ my mother or father responded by \_\_\_\_\_
2. What do you think their response taught you about your needs and feelings?
3. When I am aware of that need and those feelings today, my response is usually to: \_\_\_\_\_

Here is an example of answers to the questions for the childhood need of comfort and feeling hurt.

1. When I needed comfort from my mother because I felt sad and lonely because I had no friends, she said, “Stop whining. Don’t bother me, I have work to do.”
2. That my needs and feelings were not important.
3. I cut off from the need and the feelings. I just seem to space out and go away.

In group discussion we begin to identify the mode operating in the patients’ answers to the “today, my response is usually to:” In looking at what they learned we get clues about the beliefs of their Dysfunctional Parent modes. They are given a chart, Table 6.1 (ED ST-6) that relates unmet childhood needs to schema modes, describes their role in BPD developing and their relationship to BPD symptoms. This provides patients with an understandable explanations about how ST concepts are related to their current symptoms and problems.

**Table 6.1** The relationships among unmet childhood needs, schema modes and borderline personality

<i>Unmet childhood needs</i>	<i>Schema mode developed</i>	<i>Role in BPD</i>	<i>Related BPD symptom</i>
Secure attachment – includes safety, predictability, stable base, love, nurturance, attention, acceptance, praise, empathy, guidance, protection, validation	<b>Vulnerable Child</b> Experiences intense feelings, emotional pain and fear become overwhelming and lead to flips to maladaptive coping modes that are identified as other BPD symptoms	Intense feelings – emotional pain and fear become overwhelming Triggers flips to maladaptive coping modes that are BPD symptoms	Abandonment fears, real or imagined
Guidance, validation of feelings and needs, realistic limits and self-control. Freedom to express, validation of needs and emotions	<b>Angry Child</b> Vents anger directly in response to perceived unmet core needs or unfair treatment	Interpersonal problems as anger is larger than the present situation, so seen as inappropriate	Intense anger Stormy relationships Emotional reactivity
Realistic limits and self-control, validation of feelings and needs, guidance	<b>Impulsive/Undisciplined Child</b> Impulsively acts based on immediate desires for pleasure, without regard to limits or others' needs	Also a source of interpersonal, work and legal problems Action is usually self-damaging or potentially so	Lack anger control, Impulsivity potentially self-damaging, SIB, suicide attempts, unstable identity Stormy relationships

(Continued)

Table 6.1 (Continued)

<i>Unmet childhood needs</i>	<i>Schema mode developed</i>	<i>Role in BPD</i>	<i>Related BPD symptom</i>
Spontaneity and play Lack of love, nurturance, attention, validation, acceptance, safety	<b>Happy Child – underdeveloped</b> Feels loved, connected, content, satisfied	Identity development experiences like exploration of the environment to discover likes, dislikes do not occur	Emptiness Unstable sense of self
Parent modes suppress and reject, the needs of the child, applies to any need – particularly love, nurturance, praise, acceptance, guidance, validation	<b>Punitive Parent</b> Restricts, criticizes, and punishes self and others  <b>Demanding Parent</b> Sets high expectations and level of responsibility to others, pressures self or others to achieve them	Very common, can be a source of or suicide attempts  Common, origin of defectiveness	Self-injury Suicide attempts (frequently)  Self-injury (less frequent than in response to Punitive Parent mode)

Any unmet childhood need can produce a maladaptive coping modes that are versions of the survival responses-Flight, Fight and Freeze. When triggered a lot in childhood, they become your usual way of responding to emotional threat and happen automatically. You can learn to be aware of them and eventually to make a healthier choice that fits better with your adult life	<b>Avoidance</b> Pushes others away, breaks connections, emotional withdrawal, isolates, avoids	Common – continuum from “spacey” to severe dissociation or physical withdrawal, angry protector version	Dissociation, stress related transient paranoid episodes Unstable identity Emptiness
	<b>Overcompensation</b> Coping style of counterattack and control. Sometimes semi-adaptive	Common – Bully-Attack mode	Intense inappropriate anger Emotional reactivity
	<b>Compliant Surrenderer</b> Compliance and dependence – gives up own needs for others, people pleasing	Common and often overlooked as can flip to overcompensation	Unstable sense of self Emptiness
Autonomy, competence, sense of identity Lack of childhood needs being met leads to underdevelopment of Healthy Adult mode The more unmet needs, the less Healthy Adult mode development	<b>Healthy Adult is underdeveloped</b> Is able to meet needs in healthy way	This deficit is the source of instability in affect, behavior, relationships, self, transient psychosis, paranoia	Any of the nine criteria can be related to this deficit



Therapist sample script: “What does all this have to do with recovery from BPD?”

“Understanding your modes and the need involved is the first step in being able to make changes to improve your life. Modes represent our survival-based responses that developed to cope with core needs not being met in childhood. These responses worked because they allowed you to survive despite not having core needs met. However, they operate at a cost to you because these mode responses are too extreme for everyday use and can even be dangerous. An *example* is: you are driving along the road and that triggers a *Detached Protector mode*, you space out for a few minutes without realizing it and crash into a telephone pole.” You may not even know what the trigger was. In a way, these unhealthy coping modes are some of the damage you are left with because your childhood needs were not met adequately. You survived, but you were left with these modes that create some big problems in your functioning and keep you from having the kind of life that you want and deserve. The good news is that you can reduce the strength of the unhealthy modes and get control of them. Some may still get triggered, but they won’t take you over. You will be able to choose your action. You will, for example, be able to “refocus on the road and stay alert when driving.” However, they do not change easily. We don’t want to kid you. This may be the hardest work you have done in therapy and even your life, but it also has the biggest pay-off in improving your life. You don’t just have to take our word for it either. There is research that proves it, and we have plenty of success stories from people with problems like yours.

We believe in your ability to succeed by doing this work or we would not have accepted you for the group. We have enough hope for you that you can borrow some of ours until things start to change and you get your own hope. What we face is that the coping modes were so strongly reinforced in childhood (they allowed you to survive) and you have used them so many times that they are automatic and, like the car example, you are not even aware anymore of making a choice to use them. So the first step is to understand your experience of the modes and learn their triggers. The homework you will do over the next few sessions will help with that.”

We provide an information handout on each mode and a homework exercise that asks patients to think about and record their experience of the mode. These are included in the Patient Workbook materials and excerpted here. This learning process and sharing what they discover about their experience in the group adds to cohesiveness.

### Maladaptive Coping modes Information Sheet excerpt (MCM 1)

Survival strategies are exhausting. When they are used daily, all of your energy is used up with protecting yourself and not living. Survival strategies do not meet the requirements of adult life at work, at home, or with friends. When you use survival strategies in everyday situations people tend to see you as “over-reacting” and respond negatively. You can also be seen as the “boy who cried wolf” and not be taken seriously when you are in a severe crisis.

The good news is that it is possible to change and learn to over-ride your automatic survival responses. The first step is to *become aware* of your automatic coping style. As you become aware of your automatic or usual response, (the coping mode that is most often triggered) you can learn to access the Healthy Adult part of you and consider other choices of action. You can develop a plan for the situations that frequently trigger unhealthy coping modes in you so that you will be prepared next time. Then you can try the new coping plan and record the result. It is important to record good results from healthy coping as evidence that your Healthy Adult mode is capable and getting stronger.

No one likes to have his/her feelings hurt or to be rejected in friendship or other relationships, but people with BPD are particularly sensitive to these experiences. Unhealthy survival-based reactions include:

- Having an angry outburst and pushing the person who hurt you away (avoidance – Angry Protector mode)
- Putting someone down who you are afraid will reject you (over-compensation)

- Withdrawing and avoiding that person (avoidance)
- Staying in the situation and becoming more and more hurt and frozen (compliant surrender)
- “Jumping on the bandwagon” of self-criticism (compliant surrender)

**An example of a Healthy Adult response** would be to say “my feelings are hurt.” If the other person responds in a healthy way, then you know that this may be a safe person to befriend. If they respond in an unhealthy way, then you know this is a person to limit contact with. Expressing needs and feelings to others is one of the ways we can evaluate the people we choose to form relationships with. Unlike our childhoods in which we did not get to pick our family, as adults we can choose our friends and romantic partners.

With the Coping modes, as shown above, we begin to introduce the idea of more effective action and label it the Healthy Adult mode.

### Vulnerable Child mode Information Sheet (excerpt from VCM 1)

When a person is in the Vulnerable Child mode they feel just like a little child out in the world who desperately needs the care of adults to survive and is not getting that care (Young et al., 2003). In the Vulnerable Child mode people will do almost anything to be taken care of, and can feel as if their life depends upon getting that care. It is usually difficult for other people who have not experienced it themselves or who are not trained in BPD to understand the level of desperation that you feel in the Vulnerable Child mode. Often the person in this mode is also rejecting of, or confused by, the intensity of these feelings. You may experience this mode as embarrassing or representing weakness. You may have been told that by early caretakers and punished for expressing your feelings and needs. You may have been called “too needy” when in this mode, even by mental health professionals. It is important to know that your Vulnerable Child

mode exists because your core, normal childhood needs were not met. This is not your fault. Little children are not to blame for adults not meeting their normal needs. A part of you may feel empty. An important step in schema therapy is you accepting the Vulnerable Child mode part of you and eventually embracing this part, viewing it in the positive and caring way that you would a young child you care about.

### The Angry Child mode Information Sheet (excerpt from ACM 1)

**This mode is an innate reaction to a child not getting core needs met.** An example is a young child initially crying when frightened or hungry and, after a long time passes and no one responds, eventually having an angry outburst. When adults are in the Angry Child mode they may vent their anger in extreme or inappropriate ways. You may feel enraged and act demanding, controlling, abusive, or devaluing of others. You may flip to the Impulsive Child mode and act impulsively and selfishly to meet your needs. This is the mode in which impulsive suicide attempts and threats or self-injurious behavior may occur. You may seem reckless or even manipulative to others. Usually, when adults are in the Angry Child mode, the people around them do not understand what is needed. Even your therapists may not get it. Angry Child reactions can hook therapist schemas too. We want to be able to hear you when you are in this mode, but we will set limits on your behavior if it becomes abusive to us. We can help you take a short time out if that happens.

### The Punitive Parent mode Information Sheet (excerpt from PPM 1)

In this mode you act to criticize or punish yourself for doing something that is “wrong” according to your negative core beliefs, like expressing your feelings or needs. This mode can be an internalization

of one or both parents' or early care-giver's anger, hatred, or abuse when you were a child. In this mode self-hatred, self-criticism, self-mutilation, suicidal fantasies and self-destructive behavior occur. **You become the Punitive Parent**, punishing yourself for normal needs that your parent did not allow you to express. You describe yourself as "bad." This mode represents only the negative aspects of your early environment. Identifying a "parent" mode does not mean that there was nothing good about your parents or that you are wrong to love them. The Punitive Parent mode is the exaggerated negative based on the extremes that children experience when their core needs are not met.

After the group session in which we first discuss a mode, we give patients the set of questions shown here to complete for homework. We discuss the result in the next group session. This provides more fuel for cohesiveness and universality as well as examples of patient differences to point out and support.

What Do You Know About Your (*fill in the blank*)  
Mode? (ED ST-7)

**Group Discussion Questions**

- What triggers this mode? (For example: situations, people, or memories)
- Describe your usual feelings in the \_\_\_\_\_ mode
- Describe your usual thoughts in the \_\_\_\_\_ mode
- Describe your usual behavior in the \_\_\_\_\_ mode
- What are your childhood memories of experiencing the \_\_\_\_\_ mode?
- What do you NEED when you are in the \_\_\_\_\_ mode?
- Does the action you take in this mode get your need met today?
- What kind of response does your \_\_\_\_\_ mode action get today?

*Understanding and labeling emotions*

The third stage of GST is Awareness work. This stage requires the ability to be aware that a mode is occurring. For patients with BPD to accomplish this awareness, their limited emotional awareness that was introduced in Chapter 5 must be addressed. A characteristic of early levels of emotional awareness is the inability to recognize gradations in emotion. This prevents patients from recognizing feelings that are at a pre-crisis level. We use experiential exercises and self-monitoring of progressive complexity to fill in these emotional awareness deficits. This approach to feelings and needs is designed to support a patient in going back to the missed point in development where children learn to identify, understand, and label their own unique emotional experience. We present information about how children learn to recognize and label experiences of emotion in the course of healthy development. We explain that this is a learning experience that many patients who develop BPD missed. We discuss with them what they learned or did not learn about emotion growing up and their understanding of their emotions now. In group sessions we use experiential exercises that increase emotional awareness and games that provide non-threatening vehicles to learn emotional labeling and communication. BPD patients must develop their capacity to allow feelings to come and go as they are meant to. Their experience has been to feel overwhelmed and shut down in some extreme way. The feelings then build up until they burst through defenses, followed by extreme action and the vicious circle continues (ED F1, 3).

Work to improve the emotional awareness of patients with BPD begins with kinesthetic exercises because the sensori-motor, global level of emotional awareness is where most of them are (Lane & Schwartz, 1987; Farrell & Shaw, 1994). The Level of Emotional Awareness (LEA) Exercise (EXP 1) involves asking patients to be aware of any physical sensations, feelings, and thoughts that occur as they take slow steps toward a person from a distance of about 12 feet. The person they approach can be the therapist or another group member. We use this exercise as an emotional learning tool in a number of different ways. One is to help BPD patients better understand and form labels for their emotional experience. We see this as a prerequisite to doing emotion-focused work in psychotherapy (Farrell & Shaw, 1994). This exercise is powerfully evocative of affect related to many schemas (e.g., abandonment, mistrust/abuse, emotional deprivation, defectiveness/shame, dependency, social isolation/alienation, and approval seeking) and it is most often responded to by the patient's default Coping mode occurring

(almost invariably the Detached Protector mode). The LEA exercise is also effective in breaking through the Detached Protector mode since emotional awareness is an antidote for detachment. The exercise, as the example below illustrates, can give patients opportunities to titrate their use of the Detached Protector mode as they replace it with the ability to stay present in interpersonal interactions using more Healthy Adult mode coping.

### Patient example: LEA

In individual ST Kat described her emotional experience as globally “bad” and said it never changed. Joan used the LEA exercise with her to see what effect it might have in helping her make more distinctions in emotion. After one step forward, Kat fell on the ground saying she felt “even worse.” Joan (hiding her excitement that a change had occurred) quickly told her to “step back.” When Kat did so, she returned to the “bad” that she originally thought was the worst she could feel. Kat began to make the connection that when she took some action, her feelings changed and when, instead, she stayed immobilized, she felt stuck and miserable. Over time Kat was able to discover actions in her world outside therapy that accomplished the same decrease in “bad” that the “step back” did. Kat was in GST, so sessions were the perfect place for her to experiment with her new tool. In the first group session she could not sit in the circle of patients and therapists. Over a few sessions, she was able to move closer to the circle and, eventually, into the group circle. When emotion was high in group, she leaned back in her chair providing some increased physical distance. Later she happily told us that she was now able to “do the step back” in her head without physically moving.

Kat’s experience is a good example of how experiential exercises and the group modality can provide opportunities for emotional learning that do not easily arise in cognitive therapy. Interventions like the LEA exercise are well suited for group where a larger space and additional people are available. Patients with BPD often try to use space to modulate their affect level. Experimenting with physical proximity in group, like Kat did, provides a way to experience gradations of avoidance and a manageable way to work on

reducing the intensity and frequency of modes such as Detached Protector occurring.

Another exercise we developed, called the “Color Game”, is a safe introduction to the difficult topic for BPD patients of labeling and communicating their feelings. It addresses their need to share what they are feeling and why they have these feelings, but cuts out all the details and time it would take to hear from all of the group members. It starts with patients choosing a colored card to represent how they feel and showing it to the group.

### Exercise: What Are You Feeling? Game or the Color Game (ED F2)

This game can be played at the start of a group to have the patients identify what feeling they are currently aware of. Each color has a list of feelings. Over time patients add their own feeling words to the color categories.

**RED:** for angry, frustrated, annoyed, irritated, etc.

**GREEN:** for happy, joyful, excited, etc.

**BLUE:** for sad, depressed, tired, down in the dumps, etc.

**YELLOW:** vulnerable, scared, fearful, etc.

**BROWN:** detached, withdrawn, confused, numb, overwhelmed, etc.

- Place multiples of colored paper in the middle of the group circle.
- Everyone picks the color that matches most closely what they are feeling in the moment. They do not need to explain their feelings.
- Therapists *record* the color each member picks.
- Let them know that you will come back and talk about the game, but first you want to get to today’s topic.
- After the work of the session, a short fun activity is interjected.

Then repeat the game. They pick a color again and you record it.

### Discussion Questions

- Did your color change?
- What in today’s group led to a feeling change for you?



- If no change, why not?
- What do *you* have to do to help feelings change?
- How do our feelings help us to identify our needs?
- What is the relationship between modes and feelings?
- What do you pay attention to in yourself to help you identify what you are feeling?

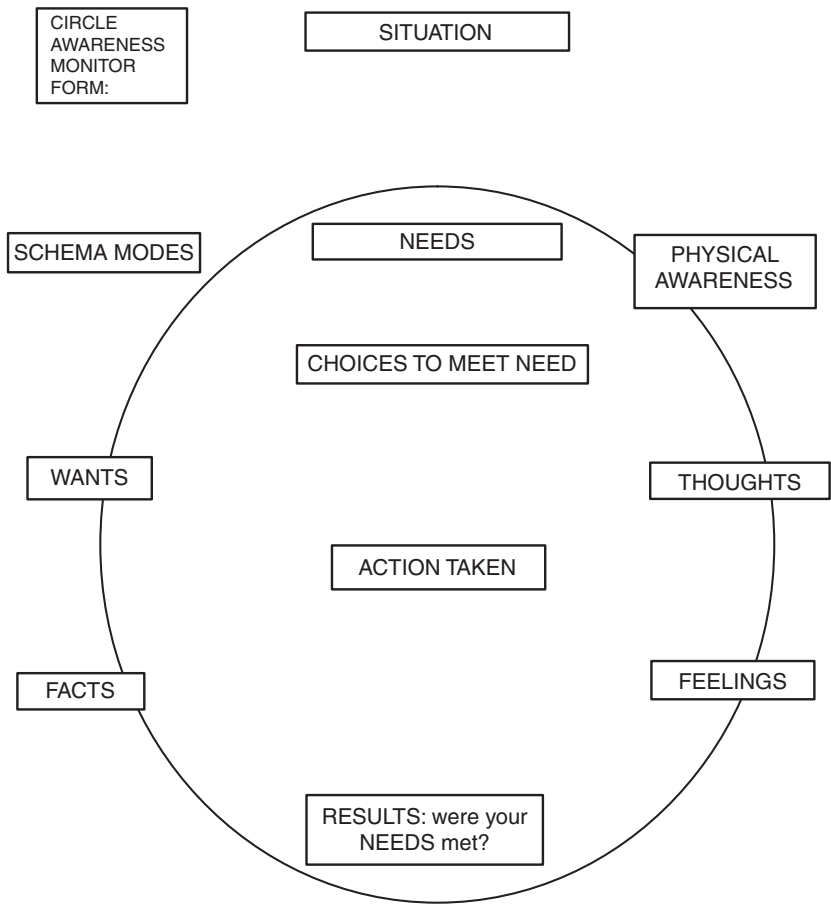
There are a number of variations of this simple game matched to how differentiated the group's level of emotional awareness is.

- We begin with basic colors and later use color strips (use paint samples that are available in stores) to begin to visually demonstrate the range and blends of feeling that are possible.
- In another variation, patients chose colors for other patients and the therapists and then check whether they match with self-report. We discuss they made the basis for making their choices.

Emotional awareness work helps correct some of the confusion about emotions that many BPD patients experience from having learned to “get by” by accepting and even using the erroneous labels that others assign to them. For example, “angry” is often the label observers assign to the Angry Protector mode. The underlying feeling in this mode is more likely to be fear. We want to help them learn about what their emotions truly are and to get comfortable with having and using the important information that our emotions give us.

### *Monitoring Awareness with the “Circle”*

Education about emotion and opportunities to increase emotional awareness provide the necessary foundation for the ability to be aware of mode states. Patients are able, over time, to gain improved self-understanding through collecting and recording information about their emotional experience, the schemas and modes that are triggered, the situation, physical sensations, their needs, feelings and thoughts. We see the therapist role in this process as involving the limited reparenting BPD patients need to identify their feelings and the underlying unmet needs that trigger them. They need this information to be able to learn to ask for help in getting needs met



**Figure 6.1** Circle awareness monitor

and eventually to develop the Healthy Adult mode skills needed to meet their own needs.

The first monitor we use is in the form of a “Circle” and is shown in Figure 6.1 (form is AW 1–1). We have found that BPD patients will complete circles with much less resistance than the usual printed forms used for monitoring. We speculate that the visual representation of movement around a circle from one aspect of their experience to another is somehow more understandable to them and more engaging. Patients objected strongly when Joan decided to put boxes on the circle so that their writing

could be more neatly contained. As we have learned to do over the years, we yielded to their preference.

We may have patients begin with just recording the situation, physical awareness, feelings, thoughts and action and later add in the other categories such as modes and facts.

### Therapist Tip: Use the Circle for Crisis Intervention

The circle can also be used very effectively for responding to crisis situations or emergent problems that patients bring into group and want to discuss. A therapist (or later in the group another patient) can put the circle on the whiteboard to involve the group in understanding the situation, identifying what is needed, and what the group can do to help. This shortens the process and involves everyone.

### *Mode awareness*

As patients are able to recognize some gradations in emotional experience and have more ability to accurately label it, we move on to mode awareness. We provide patients with summary forms to record their self-monitoring of mode experience. Since patients with BPD, at this point in treatment, are usually quite labile with frequent mode flipping, we focus on one main mode at a time. A form for patients to use to summarize the information gathered in their Circle Monitoring (Figure 6.1) is provided in AW 1–2, 1–3.

### *Safety imagery*

The ability to use safety images is another important prerequisite to the next stage in which we begin work on getting through the Maladaptive Coping modes. Healthier replacement coping strategies must be developed before we can expect our patients to abandon the only way of coping they know. After all, these were the survival strategies that worked to keep them alive in childhood and they are still experienced as protecting them from overwhelming frightening, painful feelings that occur when the child modes are triggered in the present. In addition, Maladaptive Coping modes are automatic and require the step of awareness of choice points. Safety imagery is one of the replacement coping strategies for patients to use to be

able to stay present when strong emotion is triggered rather than going with a Maladaptive Coping mode like the Detached Protector. When teaching imagery to BPD patients, they frequently claim a total inability to visualize so we begin with practice images that we have found anyone can do.

### Example: Imagining ice cream

The “ice cream cone” imagery exercise involves everyone closing their eyes (or looking down, since some patients do not feel safe enough to close their eyes yet). An ice cream cone and eating it are then described in detail. Ida uses a story about having just won the ice cream cone of her choice at her favorite ice cream store and is able to take 10 people with her. She invites the group and goes on to describe in detail tasting lots of flavors, choosing the type of cone and whatever number of scoops that your little child’s heart desires, starting to eat it, etc. She describes this scene dramatically with great enthusiasm. Patients appear to get caught up in her story despite themselves. When the group opens their eyes, she asks how many could get a picture of the ice cream cone. We have never had anyone not raise their hand. Ida then declares, “What you have just done is imagery work. Wow, all of you could do it! That is wonderful! We knew you could.” and is very positive about their ability.

### Therapist Tip: Enthusiasm

The word **enthusiasm**, which was included in the last example, is important to note. As a group therapist, when we can be open and genuine in sharing our Vulnerable Child mode delight and playfulness in an exercise we lead, it is easier for patients to get caught up in the emotion as well. It is as if we have called their Happy Child part out to play and the “game” seems like fun. Being able and willing to invest our own emotion in our interactions as a therapist is crucial for effective GST. Just as schema therapists have many differences in personality, temperament and schema profile, there are many different ways to engage with patients. Ida and Joan have distinct differences, with Ida

being more playful and effervescent and Joan calm and nurturing. Patients respond to both at different times and for different needs. What is critical is that you be genuine and conduct GST in a manner true to yourself. Of course, you must also be aware of times when your schemas and modes are triggered.

As mentioned in Chapter 5, the Group Safety Bubble is an imagery exercise that has patients put themselves and the whole group into a huge magical safety bubble. This fits with the developmental approach of ST that suggests that safety and protection initially need to come from the therapists.

### Basic Safety Bubble Imagery

“Either close your eyes or look down and take a few deep slow breaths and just feel any tension leave your body and mind. Imagine that we are surrounded by a huge transparent bubble large enough for all of us to fit inside and filling up the group space. It is a beautiful bubble with all of the colors of the rainbow. You notice that it even has a wonderful fragrance to it. It is a magic bubble that can protect us from anything outside of it. No unhealthy parent voices or critics can get through its walls. It is unbreakable – no one can get in, but you can walk in and out of it if you need to or take it with you as you move. Bring into the bubble any comfort objects that you like. You can take into the bubble anything you want that will be soothing to you and help you feel strong and safe. No one can bring anything in that could be used for harm. The bubble symbolizes the safe cocoon we have here in the space of the group. Joan and I will not let you be harmed here. We will protect you and “have your back.” All of you are valuable to us and we want you to know that here you are safe. Just take in the warmth, safety, and connections of the bubble. Stay focused on it for a few minutes and keep your breathing deep and slow. When we come back to having our eyes open, let the bubble stay protectively around us. If you feel the need for your own bubble, imagine that you have a smaller one that is just around you. It is even one that you will be able to take home with you. We will all connect with it again before you leave today.” (Instructions in EXP 9.)

### Therapist Tip: Dealing with patient objections

When it comes to imagery or other experiential exercises, patients may object to participating, saying it is “silly” or even “bullshit” and refusing to try it. We avoid ending up in a battle over this. We may say, “I am so glad that you spoke up to tell me you felt it is silly. That took courage. Good for you. I can see how you would think it sounds silly *before* trying it. Let’s see if you feel that same way after you try it. We have found it to help many people.” More often than not, they then try it. Another complaint is “I cannot possibly use a bubble.” Ida is an expert at coming up with something that will be appealing: “OK what about a brand new car, a Hummer, with all the safety measures available?” It could be a tent or whatever you can think of or the patient offers. It is important not to ignore their objections but to work with them and be flexible.

We “choose our battles” with BPD patients and usually limit them to situations that are dangerous for them or others. Arguing with them usually triggers their Angry Child mode or a Maladaptive Coping mode that will make it even more difficult to reach them. A transitional step to recommend is an individual Safety Bubble – same image, but a separate bubble of their own.

### Therapist Tip: When “nothing works”

On rare occasions we will have a patient who will not try anything. Here is an example of what we say: “Okay, I will respect that today, but I will ask you on another day to respect me and try the exercise. Is that a deal?” Or we take the approach of “Good that you are taking care of yourself. Would a pillow or blanket help you feel safe enough while we try the exercise?” Usually they take the soothing object and you can incorporate that and them into the imagery. For example, “So we are all in this protective bubble together and we can see Jean over there with the comfort blanket wrapped around her, looking peaceful and calm.” You can pull her into the bubble in gradual steps. For example, have her come closer in imagery and reach out to take her hand from

the safety bubble or whatever creative thought that comes to you. If you keep trying, stop at two ideas and let her safely be in the room. She may not be able to join at first and as long as that is acknowledged, it does not have to be such a big deal.

**Safe Place images:** After doing some of the safety imagery work as preparation we move on to the Safe Place image. Before going into the imagery we discuss safe places in general. We have learned not to assume that patients will have a safe place or even be able to recall *ever* feeling safe.

### Therapist Tip: The Safe Place Image

We help the group come up with a Safe Place image by offering what our safe places are. Joan talks about being at her grandmother's house in her flower garden or up in her attic sitting on a cedar chest. This often elicits a patient remembering a safe grandmother image. We brainstorm with the group for those who say they cannot think of one. We list many of the things that we have heard from BPD patients over the years: school, a particular teacher's classroom, a safe relative, a friend's house, a tree house, up in a tree, climbing a mountain, a trip to camp, riding your bike, an imaginary place like Oz, with a fairy godmother, at church, etc. We can honestly tell patients and you that we have always found a Safe Place image for every patient, possibly because we expect to and will stick with it until we do. Keep in mind that inevitably, in a BPD group, someone will have been abused in one of the Safe Place images given as an example. That is a time when it is important to acknowledge that we "are all different" and sincerely say some version of the following statement: "Oh, that is awful, you certainly won't want to use that one."

We use a variation of Young's basic instructions for the Safe Place image (Young et al., 2003). With a warm, soothing voice we ask them to close their eyes or look down and to be aware of what it looks, feels, smells, and sounds like in great detail. When we first work with the Safe Place image we do not specify the age or mode of the patient, just that it is a place where they felt safe.

### Safe Place image (EXP-10)

You can use your image to soothe your vulnerable child or reduce high distress or to replace the upsetting images of flashbacks.

#### *Instructions*

Let an image come to mind that represents a Safe Place to you. Don't push it; just be open to whatever Safe Place image occurs. It can be like a movie scene, slide, photo, or it may be an actual memory. It can be something from your life, imagination, a book, or movie. You can bring anything that is safe and comforting into your image. Make it your own. Don't worry if you have some difficulty at first getting a strong image. We will discuss it in group and help you develop an image that works for you.

1. What do you **see**?
2. Can you see yourself?
3. How old are you?
4. What else do you see?
5. What **sounds** do you hear?
6. Does it have a **smell**?
7. How do you **feel** in this place?
8. How does your **body feel**?
9. Is anyone else there? Remember, only safe people are allowed.

**Self-talk** for the Safe Place Image: "I am safe," "I control this space, no harm comes to me here," and "I feel calm."

Add your own words: \_\_\_\_\_.

Name your Safe Place so that you can bring it to mind quickly and easily. For example, Grandma's house, the Tree house at home, Mrs. Smith's classroom. \_\_\_\_\_

We give them the instruction to practice the image at least once a day. Later on we have them draw a picture of their Safe Place image, or find a picture or symbolize it in some visual way so that they can put it up somewhere they will see it regularly. Once the Safe Place image has been established, we begin group with a short exercise using it instead of the Safety Bubble. If the group



is doing very difficult work, struggling in some way, or we want to reinforce the group's connections, a Safety Bubble around all of us in our Safe Place images can be added for extra safety and protection. In that case we also mention the shared strength of our connections with the group. This begins the addition of the group to imagery that will become important when we are doing imagery change work for the Vulnerable Child mode.

### *Safety plans for life-threatening BPD symptoms*

Attention to life-threatening symptoms must be included in any treatment for BPD. We assess for life-threatening symptoms and the safety level of members of the group in the pre-group sessions. In the first group sessions we collaborate with patients to develop individualized safety plans for self-injury and suicidal urges. A number of different modes can have safety issues for BPD patients. When ST work gets through the Detached Protector mode, it is the Vulnerable Child mode which is experienced. In the Vulnerable Child mode, patients often experience extremes of fear, heart-breaking loneliness, hopelessness, feeling unloved, etc. They may also experience the helplessness and hopelessness of their little child. Self-injurious behavior may be used in the Vulnerable Child mode as a desperate effort to distract from these overwhelming feelings. Mode flipping can occur taking them to the Punitive Parent mode. In the Punitive Parent mode where intense shame is experienced, there is a risk of self-injury to punish themselves. Slicing an arm may seem less painful than the emotional pain from the Punitive Parent mode's shaming. A patient of ours begged us to "just let me cut off one of my toes as punishment. It would hurt so much less than the guilt I feel." A common thought in the Punitive Parent mode is "I am bad and deserve punishment." Patients may experience the Punitive Parent mode as a voice or command they feel unable to resist. Another flip that can take place is from Vulnerable Child mode to the Impulsive Child mode. In this mode potentially dangerous behavior to end the Vulnerable Child mode feelings can occur. Patients may take drugs, engage in risky sex, or act on a suicide plan when in the Impulsive Child mode. Table 6.2 illustrates the complex relationship between self-injurious behavior and modes (Farrell & Perris, 2010).

In the early months of therapy, when patients are feeling more and experiencing the Vulnerable Child mode, it is important that they have a safety plan to use to cope with these feelings so that they do not resort to default behaviors of self-injury or suicide attempts. We see them feeling more and being less detached as "progress," but they can feel overwhelmed and frightened and be unsafe when this occurs outside of therapy sessions. They

**Table 6.2** BPD and the complexity of self injury – a mode approach

<i>Modes</i>	<i>The function of self-injury</i>
Vulnerable Child	Transform emotional pain into physical pain, end emotional pain by switching focus A desperate communication of need for nurture Suicide-attempt to end pain
Angry Child	To be heard To connect
Impulsive Child	To get attention from others <i>now</i> To have an endorphin or adrenalin rush
Detached Protector	To feel “something” To no longer feel numb or dead
Punitive Parent	To punish the Child modes

detached from the Vulnerable Child mode in childhood for good reasons and as they begin to re-experience those feelings, they can again feel threatened enough that they consider extreme and even life-threatening actions to end the pain. Their safety plan must be a response to the Vulnerable Child mode need. Patients are usually not very good at identifying, let alone meeting, their needs. This is where Mode Awareness work comes in. We first give them the simple formula of asking themselves “What do I need to feel less of?” The answers are things like: “less pain,” “less fear,” “less unloved,” “less bad.” Then we brainstorm in the group about what it would take to feel less of whatever they have identified. Often the first way to feel less will be some form of detachment, albeit healthier than self-injury or suicide. We cannot expect patients to give up coping by avoidance all at once. It is important also to acknowledge that there are situations in the present when detaching is appropriate, for example, during a physical attack you cannot protect yourself from. Two that are common for our patients are re-experiencing trauma by body memories, or times when an extreme impulsive action is being contemplated. Choosing a “safe” form of detachment at such times can be a good choice. We suggest things like taking a nap with an alarm set, eating a comfort food, or distracting with watching a children’s movie. Often the need is “safety.” This may require help from another person, such as being with someone safe, talking to a friend, calling a crisis line, going to

the crisis unit, or going to an emergency room. Safety may require getting rid of items that could be used for a suicide attempt or self-injury. For example, a friend could take the razor blades or medication out of the house. An Emergency Plan Example is given: BEH 1–1, blank form BEH 1–2.

We discuss patients' emergency plans in group and brainstorm the actions to take to ensure safety. We make sure that everyone has one by the end of the second group. Sometimes it is worked on further in an individual session. It is always shared with the individual therapist when one is involved. We emphasize that fellow group members cannot take the responsibility of being called to prevent suicide or serious self-injury. We have a phone tree of the patients in case of emergency group cancellation and other needs for contact. Patients agree if they want others to have their phone number to call just to talk or for support in non -life-threatening situations. Usually patients initiate the sharing of phone numbers.

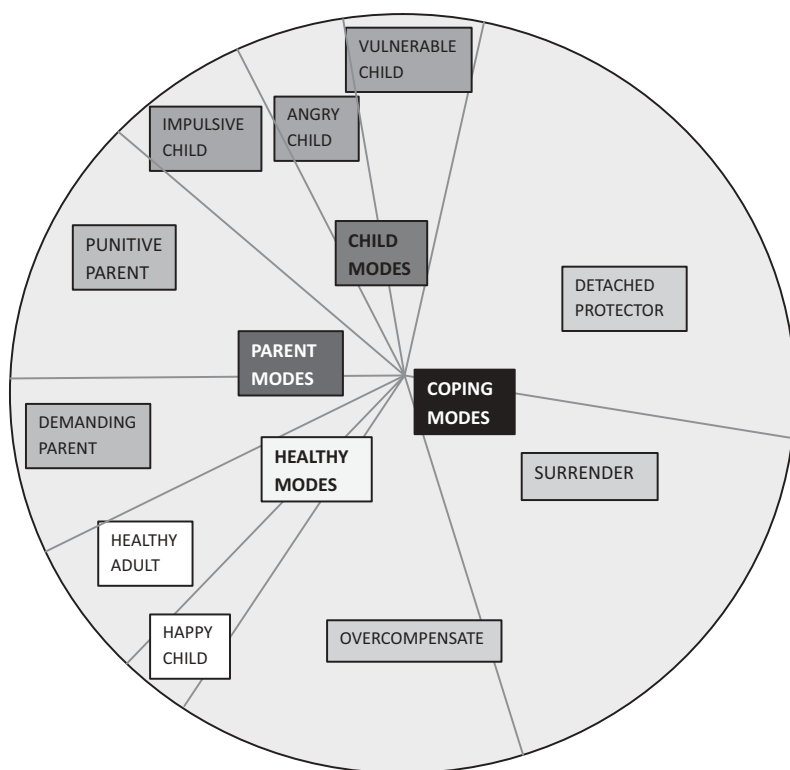
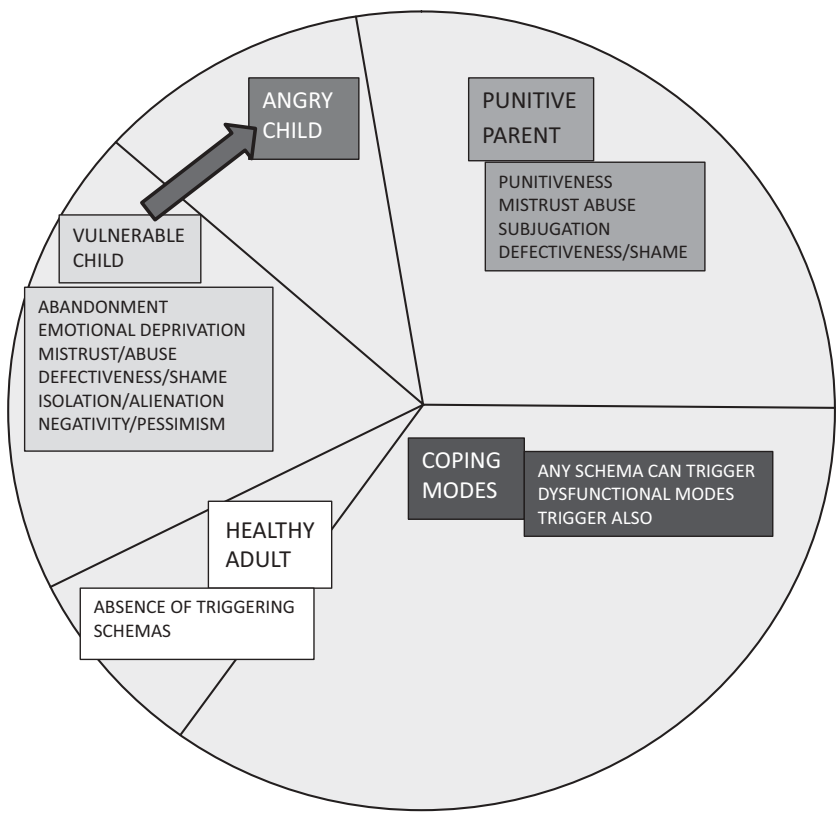


Figure 6.2 Mode conceptualization example of a patient with BPD

*Review and case conceptualization*

When the problems to be addressed in GST have been defined in terms of ST goals and agreed upon by therapists and patients, we begin to put them into a “case conceptualization” form. We usually don’t use the word “case” with patients as it seems too distant and impersonal. We talk about this document as a Mode Conceptualization. The first version we use is a simple pie chart that shows how much of the patient that mode takes up. Figure 6.2 shows a typical first Mode Conceptualization for a patient with BPD. Figure 6.3 shows a more advanced version that includes schemas as triggers of the mode.



**Figure 6.3** Mode conceptualization example of a patient with BPD showing schemas as triggers of the mode

We keep the Mode charts available in the group room and make sure patients have their own copy to work from.

In addition to the pie-chart for a visual model, we also work on operational plans that list the progressive steps of meeting the goals that are individualized for each patient by mode. An example of the early plan is shown in BEH 2-1 to 2-5.

At the end of 6–8 weeks we begin filling out a summary form of the information patients have collected about their mode experiences and the way they understand the relationships among current life problems, modes, and the beginning of a plan for change. These can be worked on in individual sessions if that is part of the format of the treatment you are providing. It should be shared, however, with the group and can be completed in group sessions in the primarily group format. The plan shown in BEH 3-3 acts as the first road map for the group's work.

Over the first few weeks of Stage Three of GST: Mode Change Work, we also complete an adaptation of the traditional Case Conceptualization originated by Young (2000). This is included in REF 5.

# The Course of Group Schema Therapy

## Stage Two: Schema Mode Change

J. M. Farrell and I. A. Shaw

After safety and initial bonding with therapists and other group members are established, the initial education component and safety plan completed, and patients have some awareness and understanding of their mode experiences, the group is in the “working group” stage and schema mode change becomes the focus. This point occurs around week 12 of sessions, depending upon whether you are in the once- or twice-a-week meeting format. We have observed that the development of the group into the working stage occurs faster in the group meeting twice weekly, although empirical validation of this must wait for the completion of the multi-site GST trial. As we have emphasized throughout, the work of GST is not linear, and change at this level occurs in small steps with occasional leaps both forward and backward. This also applies to the schema mode change stage. The presence of eight or more patients adds variance to the progression of the therapeutic work. Sometimes what is added are road blocks and sometimes additional fuel for the therapeutic process.

The ST model for Borderline Personality Disorder (BPD) and the core interventions (see Young et al., 2003; Arntz & van Genderen, 2009) are the same when implemented in the model of GST presented here (Farrell et al., 2009; Farrell & Shaw, 1994, 2010). The four core interventions of ST are: limited reparenting, experiential or emotion-focused work, cognitive work, and behavioral pattern breaking. Some aspects of their form must be adjusted because of the increased number of patients, and others adapted to make use of the power of the therapeutic factors of group (discussed in Chapters 3 and 4). Limited reparenting in GST is discussed in Chapter 4.

This chapter describes the adaptations for use in group of the other three types of intervention for mode change work. The specific interventions are arranged according to their type and by the main mode that they target. We have focused on the five main modes identified by Young et al. (2003) as central in BPD: Vulnerable Child, Angry Child, Detached Protector, Punitive Parent, and Healthy Adult. We have added the Happy Child mode, as we see this as an important healthy mode to strengthen. It is almost non-existent in BPD patients, but can be a source of hope and motivation to help them stay with the difficult work of schema mode change. GST is particularly conducive to play. The types of intervention are presented in the general order in which they occur in treatment: cognitive, experiential, and behavioral pattern-breaking. The awareness component of BPD treatment, that we see as a prerequisite to the other interventions (Farrell & Shaw, 1994), is discussed as it applies to each mode. Many of the interventions are not purely one type; they integrate various combinations of experiential, cognitive, and behavioral change work. For example, mode role-plays include aspects of all three. A unique feature of ST is the integration of the three major types of psychotherapy interventions, often separated in other approaches. As previously stated, we speculate that this is one of the reasons for the greater effectiveness of ST (Zanarini, 2009). The general steps of mode change work are listed below.

### The steps of mode change work

1. Understand what modes are and how they are related to the problems that you want to work on. Understand your problem in Mode terms.
2. Be aware of what your own experience of each mode is.
3. Be able to identify your modes when they occur.
4. Understand the unmet needs that underlie the child modes.
5. Understand the old survival purpose of the unhealthy coping modes.
6. Evaluate whether in the long run the old coping strategy meets your needs.
7. Decide to change your unhealthy coping mode
8. Identify a healthy coping behavior that can accomplish meeting your present need in a way that allows you to have a healthy life.
9. Be able to identify dysfunctional parent modes.

10. Be aware when parent modes are operating.
11. See the parent mode as “not you” in order to get rid of them. Part of this may be to identify whose voice your parent mode comes from.
12. Be able to access your Healthy Adult mode strengths and work to strengthen your connection to him/her.
13. Be able to access your Happy Child mode for joy and fun.

### **Maladaptive Coping modes**

We begin with the Maladaptive Coping modes as they are what BPD patients first present with, particularly in a group. They are the old protective survival strategies that allowed them to survive childhoods in which core needs were not being met. MCM-1 is an information sheet on these modes.

#### *Overview of Coping mode interventions in Group ST*

#### **The goals for all of the Maladaptive Coping modes**

1. Get through the Maladaptive Coping modes or help patients put them aside, so that the Vulnerable Child mode can be reached.
2. Limit any destructive effects on the group from the more aggressive Avoidance Coping mode (Angry Protector mode) or Overcompensating modes like Bully-Attack mode.
3. Facilitate patients having the experience that being vulnerable (i.e. expressing feelings and needs) is responded to positively in group, whereas Maladaptive Coping modes have negative effects and responses and do not lead to needs being met.
4. Reduce the frequency and intensity of the occurrence of Maladaptive Coping modes over time by increasing patients' awareness of choice points.
5. Replace Maladaptive Coping modes ultimately with healthy coping behaviors, which are initiated by the Healthy Adult mode of the patient.



The main Maladaptive Coping mode found in BPD patients is Avoidance, and the form it most commonly takes is the Detached Protector mode (Young et al., 2003). The other forms of Avoidance Coping, such as the Angry Protector mode and the Detached Self-soother, also occur in BPD. Less common, but still present in some patients, are the other maladaptive coping styles – Compliant Surrender and Overcompensation (see Chapter 2 for definitions of modes). We see the Angry Protector mode and Compliant Surrender fairly often in our groups. We also encounter the Bully-Attack mode (Overcompensation) on occasion, particularly in our male patients. In this chapter we focus on the Avoidance Coping style, primarily the Detached Protector mode. Whatever maladaptive coping style or combination they have, patients need to become aware of when and how it operates in them, its effects on their interpersonal life, and to address the question of whether the action of the mode meets their underlying need. When patients can tolerate the initial distress that they experience in connecting with their Vulnerable Child mode, they will also be able to take in the safety, protection, comfort, caring, and support that the therapists and the group offer. This is critical for the emotional healing of the Vulnerable Child mode.

As discussed in Chapter 4, the effects of modes on the group must be addressed, and depending upon the mode, empathically confronted or limits set by the therapists. The Avoidance and Compliant Surrender Coping modes operate more quietly, with less effect on interpersonal relationships than the Overcompensating modes, which affect others negatively and elicit negative responses from the social environment. Limited reparenting interventions with Bully-Attack mode consist of limit setting and empathic confrontation with escalating directness. As previously described, empathic confrontation involves the therapist empathizing with the patients underlying pain and need while challenging the behavior of the mode. This must be done from the bond that has formed with the patient through limited reparenting. Limit setting is also used. Patients in disruptive modes such as Bully-Attack are reminded of the group ground rules and warned that if the Coping mode behavior is not stopped, they must leave the session for a time-out or go to the designated safe space in the group room.

The Maladaptive Coping modes of the group members need to be assessed (Chapter 5) and taken into consideration when planning the group's work. The general steps of change for any Maladaptive Coping mode are similar and are listed below. The ST interventions to accomplish them are described by type of intervention in the sections that follow. Most of the interventions described for Detached Protector mode are also effective with the other

Maladaptive Coping modes with minor adjustments. These adjustments are described at the end of the section.

### The steps of Schema Therapy to change Maladaptive Coping modes

- Awareness work – mode monitoring: be aware of the Maladaptive Coping mode, first in retrospect and second the “early warning signs” that the mode is beginning to operate.
- Cognitive intervention – Pro and Con exercise: make a decision about whether to change your old coping style (mode) by evaluating its effects and whether it meets your needs.
- Experiential interventions – Safety imagery, experiences of limited reparenting, and the group responding positively to expressions of feelings and needs (i.e., vulnerability). Learn healthier coping and ways to get underlying needs met (e.g., risk asking directly).
- Behavioral pattern breaking work: practice using the healthier coping behavior and record the results. This practice begins in the group and then moves to your life.

### *Awareness interventions with the Avoidance Coping modes*

Maladaptive Coping modes are automatic, deeply entrenched survival strategies that are not experienced as choices, nor are patients consciously aware of their operation at the beginning of treatment. Consequently, the first steps of change are education about the mode and its function and helping patients identify the Maladaptive Coping modes they are using and the needs that underlie them. For this purpose, we begin with awareness work, kinesthetic and emotion focusing exercises, and self-monitoring. Awareness is a central intervention to break through the Detached Protector mode and allow a person to be more present and in touch with their emotions. The Experiential Focusing Exercise (Farrell & Shaw, 1994) is used to increase overall awareness of sensation, thought and feeling. It is described in Chapter 5 and the exercise with patient examples is included there.

Another experiential exercise that we use to increase awareness of the Detached Protector mode is shown here. This exercise is a safe and even

fun way to work with the effects of being in the Detached Protector mode in the group without singling anyone out. It demonstrates how it feels to be detached and how others in the group are affected by the break in connection.

### Exercise: Experience the Detached Protector mode

Two people are asked to volunteer for a demonstration of Detached Protector mode. They are told: “Hold the paper up in front of your face while I ask you some questions.”

“What is happening in the group right now? How do you feel right now? Do you feel cut off from the group?”

Thank the volunteers, then shift the discussion to the rest of the group’s experience. Ask them, “Could you tell what was going on with the people behind the paper? How did you feel not to be able to make a connection with them?” We make the point that this is what happens when someone is in Detached Protector mode in the group. We discuss the experiences of the rest of the group and experiences detaching outside of group. We explore with them how they could address the Detached Protector mode when it occurs in the group so that everyone can feel safe, stay connected, and have their needs met. This experiential work with Detached Protector mode flows nicely into cognitive work such as a “pro and con” list.

The **Mode Awareness** forms and Circle Monitoring described in Chapter 6 that facilitate patients collecting information about their mode experiences, including the early warning signs and whether the action taken meets their needs, are a prerequisite to mode change work. Patients sharing the results of their monitoring in the group can help increase the awareness of others. Often patients are able to recognize the affective and bodily (physical sensation) cues that others describe as experiences they also have, which allows them to be more aware of their experience of the mode. For example, “Gee now that Jenny describes the beginning of Detached Protector mode as all of her energy going up into her head, I think that happens to me too. I just never knew what that experience was before.” Giving Maladaptive Coping modes a personalized label can help make the concept more meaningful to patients (e.g., “tough Katie,” “the mask”). Group members can assist with

these personal nicknames. The same mode awareness work is done with the Overcompensating and Surrender Coping modes. An example of a problem identification and mode awareness monitor is shown in Table 7.1.

We talk to patients about watching for “clues” that a schema trigger is occurring or mode state is operating. We define as a clue, times when patients notice that their reaction is “too big” for the present-day situation. We suggest that this means that the reaction is multiply-determined – part of their response is to something in addition to the present situation. The group works together to figure out what the “something” might be based in their childhood or adolescence. This straightforward approach with the idea of clues seems to appeal to patients. It is a neutral way to suggest that they are “over-reacting” without using a word that alienates them by its perceived judgment. We can also say that anyone else with your temperament that lived through your childhood experience would have the same “big reaction” (before ST, of course) (ED ST 9: Clues That a Mode is Operating).

### Patient example of a “too big” reaction

Judy was punished severely as a child by her mother whenever the depressed mother was unhappy. This was unpredictable to Judy as it had little if anything to do with anything she had said or done. Whenever Judy saw a frown on the group therapist’s face she ran into the corner and curled up in a fetal position. That is what she did to protect herself from her mother’s kicks. Her therapist had no idea what Judy was responding to as she was unaware of furrowing her brow. One of the other group members observed Joan furrowing her forehead sometimes and wondered if that was what Judy responded to. Judy said yes. Joan was able to explain that she furrowed her forehead when she was thinking hard about something without realizing it and she probably did that sometimes in group sessions. They came to an agreement that Judy would let her know when she saw what she thought was a frown and Joan would check her forehead and reassure Judy. This is the kind of situation that can happen in a mixed group and precipitate a BPD patient leaving the group. In GST this is the kind of coping mode reaction that we discuss hoping to identify the underlying need (for Judy to be safe) and a more effective way to meet that need now, which was not available in childhood (asking Joan).

**Table 7.1 Problem identification and mode awareness example**

<b>Problem I experience today: intense fear, panic when I think I am being left alone, abandoned. I feel it at the end of therapy sessions. It is crazy. I feel really out of control.</b>	
Trigger— What situation starts your reaction?	I get anxious out of the blue, when I am alone. My level of fear is that of a little child. I start to feel panicky and think, “I cannot do this on my own.”
Feelings	Fear, panic, anger
Bodily sensations	Heart beats faster, rapid or shallow breathing, hold breath
Thoughts (these often develop later on – thoughts, beliefs)	Something bad will happen. What if someone comes to the door? What if a fire starts? What if the electricity goes off? What if they never come back? They don’t care about me or would not leave me – I don’t matter, my needs don’t matter. I should not be afraid, this is normal – I am weak and defective, and I deserve punishment.
What Mode are you in?	Vulnerable Child
How do you recognize it?	Feelings of intense fear, memories of abandonment, heart races, thoughts: this is unbearable, action tendency: desperate to connect.
Clues (early warning signs) that a mode was triggered or operating	My emotional reaction, thoughts, and behavior in response to a therapy session ending are too big for the situation.
Need present – childhood and adulthood	Child: normal care from parents – protection, reassurance, support, comfort Adult: connection, companionship
Childhood connection (may not be conscious – many of these are early and preverbal – only emotions and bodily sensations are stored)	All I can think of is my parents left me alone at home for hours at night when they went out. I think it started when I was 8 years old. Nothing bad happened to me that I remember.
Is a Coping mode involved?	Detach: space out, lose time, I watch TV, binge on potato chips and dip.
Automatic behaviors	Overcompensate: at age 12 I let boys I didn’t know well come over when parents were away – I acted as if dangerous things were safe. Today I sometimes have unsafe sex.
As an example, one of each style is given	Surrender: I feel scared and lonely, worthless – then I punish myself by cutting or swallowing something harmful.

*Cognitive interventions for maladaptive coping modes*

As described in Chapter 6, the main cognitive interventions we use are adaptations for group of: education, pro and con lists, identify cognitive distortions, cognitive reattribution, and flashcard use. We provide information about how maladaptive Coping modes develop and facilitate patients discussing how it applies to their childhoods. This is often the beginning of sharing information at a deeper personal level. We develop **pro and con lists** for being in Detached Protector mode (or other Maladaptive Coping mode) as a group and debate them thoroughly. It is helpful for the therapist to write them on a whiteboard to help with focus and allow patients to see the balance visually. We also have them record the pros and cons that apply to them independently (MCM 2 is an example pro and con list, MCM 3 is a blank form). We include looking at the disadvantages to the group as a whole of patients remaining in Detached Protector mode during group sessions. A creative way to approach this in a group is to put the Detached Protector mode on trial in what is referred to as “The Court Exercise” (van Vreeswijk & Broersen, 2006).

We provide education about how the Maladaptive Coping modes develop in childhood and acknowledge the adaptive and even survival value they had at that time.

**Sample therapist script: Unhealthy Coping modes**

Unhealthy coping modes are survival strategies from childhood that have become automatic and are triggered whenever a situation, thought, or feeling occurs that is connected with past danger. This triggering usually occurs without conscious awareness and leads to a disproportionately large emotional reaction to situations that are not currently threatening, but have some similarity to one that was when you were a child. For example, as a child the frown on an abusive parent’s face may have meant a beating was coming. As an adult, the frown on a therapists face may mean a lot of things, but one of them is not that a beating is coming. Nonetheless, your reaction emotionally is to detach (Detached Protector mode) because that is what saved you as a child. So, one can say that your “big reaction” today does not match the present – it is “too big”, but it did match the past situation

where it originated. The amygdala, the part of the brain which governs our survival responses of fight, flight, or freeze, does not make fine distinctions like past versus present, so it triggers survival action for both. In this example, a frown means “hide in some way” – physically or psychologically.

The explanation described above can be adapted for Overcompensation or Surrender modes also.

Identifying the cognitive distortions that maintain schemas, which trigger modes, is a foundation intervention of ST. The homework shown here is an example of the way we work with identifying the distortions and facts that maintain the Maladaptive Coping modes. As you can see, we do not assume that our fact will necessarily be compelling to our patients. We ask them if they are more influenced by the “fact” or the “distortion.” The example below answers “fact,” however, our patients in the beginning often answer “distortion.”

### Cognitive distortions maintain unhealthy Coping modes

Be aware of and record any time that you notice as **catastrophizing** (building something that is difficult up in your mind as “impossible” or “devastating” because schemas are triggered) or **negative** forecasting (predicting a bad outcome as inevitable) during the week. Record your version of this **distortion**, then list what you know to be the **facts** that dispute the distortion. Also record the effect that looking at **facts** had on how you felt and what you did.

**Example distortion:** “If I risk thinking about childhood experiences, it will be so painful and devastating that I will die or go crazy.”

- Effect on how you felt – “I detached almost immediately, as soon as I was aware that some feeling was coming.”
- Effect on the action you took – “After a while, feeling detached was so uncomfortable that I scratched my arm to feel something other than numb. When I feel numb I don’t feel like I am real.”

**Example of facts:** “I am in a hospital and I have therapy every day with experienced therapists. This is the place to risk connecting with my Vulnerable Child and the scary feelings from my abuse.”

- Effect of facts on how you felt – “I felt less anxious when I reminded myself that **now** I have help and support from people who care, unlike when I was a child.”
- Effect of facts on what action you took – “I was able to do the imagery exercise – see my Vulnerable Child and allow the group and therapists to be comforting and compassionate.”

Were you more affected by facts or the distortion? “This time, I seemed more influenced by the facts.”

(MCM 4: Handout on cognitive distortions.)

Another group cognitive intervention for the Detached Protector mode called “Double Asking” was developed by Perris (2010). Patients agree that if they think another patient has not answered the question, “What mode are you in?” accurately, they can ask a second time, and the other patient will reconsider and attempt a more accurate answer. We use this frequently when patients answer “Healthy Adult mode,” but seem more like the “good patient” version of Detached Protector mode.

### *Dialogues or mode role-plays with Maladaptive Coping modes*

An intervention used in individual ST for dialogues between a patient’s modes, referred to as “Chair Work” (Kellogg, 2004), can be adapted for group use. The group allows us to fill the chairs with people. We have found that this approach meets with less resistance from BPD patients than empty chairs. Patients comment that it seems “more real” to them and they feel “less silly.” We speculate that at their early level of emotional development, they do better when they have tangible “objects” to interact with. We think that the ST goal for mode dialogues – that the patient is able to conceptualize that the unhealthy mode parts of him/her are not part of the “core” self – is demonstrated in a concrete way when these unhealthy parts are played by other patients. In a homogeneous group, the involvement of all of the



patients in some way in the mode dialogue or role-play takes the place of the multiple individual repetitions.

Group mode role-plays are an integration of cognitive, experiential, and behavioral pattern breaking interventions. When a person takes on the role of a mode or a character, cognition, affect, and behavior are all involved. We see this as one reason for the power of this intervention. In group we have the added benefit of enough people to play a variety of roles – any mode, or character from their life, another patient's life, or even the other patient. We can rehearse and rewrite countless scenarios, pulling from the patient's history – what actually happened or a rewritten version, the present, what one would like to have happen, what one fantasizes about, etc. When using mode role-plays for changing Maladaptive Coping modes, a progression of difficulty should be considered.

#### Progression of actors in mode dialogue/role-play

1. Patient 1 observes, another patient or therapist play the roles of his/her Maladaptive Coping mode and Vulnerable Child or Healthy Adult (with varying amounts of therapist and group support).
2. Patient 1 plays the Maladaptive Coping mode, another patient or therapist plays his/her Healthy Adult and Vulnerable Child modes.
3. Patient 1 plays his/her Healthy Adult mode with supporters (therapist, peers) in dialogue with the Maladaptive Coping mode and Vulnerable Child played by others.
4. Patient 1 challenges his/her Maladaptive Coping mode from the role of his/her Healthy Adult mode including protecting and advocating for his/her Vulnerable Child.

The rest of the group either stands with Patient 1 for support or joins one of the mode roles.

When patients are the protagonists in mode role-play work with the Healthy Adult mode and the Detached Protector mode they can be very effective devil's advocates as they know all too well the responses likely to be given in that mode as well as the counter arguments to make.

### Therapist Tip: Involve the group

We suggest having at least one group member, and preferably more, involved in all mode role-plays. This is a way to include the group in what otherwise would be individual work. Including peers in this way does not diminish the emotional salience of the work and it makes it more salient for the group than if they merely watched. Observers can be given a role like observing the nonverbal, facial expressions, perceived anxiety level, etc. Others can have the role of cheering observers for the Healthy Adult or critics of the Maladaptive Coping mode. Be creative in your use of the rest of the group, keeping in mind that any group involvement has the potential to facilitate group therapeutic factors like cohesiveness and belonging.

Vicarious learning in Mode role-plays can be an important tool to use to get through the Avoidance coping style modes.

Using filled chairs with some patients as observers to the role-play dialogue adds the group therapeutic factor of vicarious learning. The Avoidance Coping modes in BPD patients usually get stronger when they are confronted directly, even when it is empathic confrontation. We use role-plays frequently when challenging the Punitive Parent mode. We discovered that those role-plays have a good deal of power in getting through Detached or Angry Protector to reach the Vulnerable Child.

### Patient example: Vicarious learning

One of our patients was very resistant to discussing or even looking at her Punitive Parent mode, despite having been “rented out” for sex as a child by her adoptive parents. Jane’s Coping mode tended to be Angry Protector. She came into group on a day we had planned to do some Punitive Parent mode work announcing in an angry voice directed at Joan, “I am not answering any questions today.” Joan acknowledged hearing her. The group did a mode role-play in which a patient, Diana, played her own Punitive Parent mode and Joan played the Good Parent defending the Vulnerable Child mode

(played by another patient). After a short intense interaction, Joan said, “It is time for you to leave, you old bitch. Get out of here and leave Diana alone!” (This language and approach were appropriate for the patient’s experience and the severe abuse from her adoptive mother.) The rest of the group applauded and the patient playing her Punitive Parent mode nodded smiling. Ida asked her “What did you like best of what Joan said in your defense?” Jane, who had been sitting at the edge of her chair while the “banishing” was going on, jumped in immediately “I loved it when you said ‘get out of here you old bitch.’” She followed this with talking about how she wished she could do that with her mother, but was afraid to. Diana said, “I can understand that, I was scared at first. I liked everything Joan said to her and the “old bitch” was the best, because that is really what they are. I am sick of living with her in my head; I want her out for good.” As the session continued Jane shared some more information about her childhood that neither the group nor the therapists had heard before.

When Jane’s Angry Protector presentation was empathically confronted in previous groups, she either charged angrily out of the session or shut down. This was the first occasion of her revealing such personal information to the group. This example and that of Pat in Chapter 4 illustrate the value of vicarious learning in getting around Maladaptive Coping modes. The use of mode role-plays with the Child and Parent modes are discussed in the sections that follow.

### *Experiential interventions: the Detached Protector*

We have developed several different approaches using experiential exercises to break through the Detached Protector, as it is a prominent mode in BPD patients and it interferes significantly with ST interventions. Young et al. (2003) tells us that after a few sessions, time spent in Detached Protector mode is essentially wasted time. In Detached Protector mode a patient is just not accessible to psychotherapy. One advantage of doing emotion focused work in a group is that affect can be amplified by the mere presence of more people in the therapy space. This amplification assists the goal of getting through Detached Protector mode to elicit the implicit knowledge and associational memories that accompany affect. This emotional material

can then be explored to learn more about the root experiences of a patient's schema modes which will be helpful when imagery rescripting is done. Often the experience of doing beginning imagery as a group has enough impact to create a chink in the armor of the Detached Protector mode.

We use adaptations of the Connecting Web exercise (described in Chapter 6) to break through the Detached Protector mode by providing the need of the Vulnerable Child mode for connection.

### Using the Connecting Web exercise for Detached Protector mode

The basic instructions for the exercise are described in Chapter 6.

- To use the web for the Detached Protector mode we ask everyone for permission to tug on the yarn connection to them if we think they are detaching. The therapist is included in this. The web is left in place during the session, so patients become aware of their Detached Protector mode operating when others give them a tug. We tell them that the idea is not to “catch you,” rather to let people know if we feel they are disconnecting, to make sure that we are strongly connected with everyone in the group as everyone's presence is important. The therapist may purposely do something to seem in Detached Protector mode so patients can notice it and tug.
- There are additional steps possible from this exercise for the Detached Protector mode. One is to use a signal that represents a tug on the connecting string. We use our “pinkies” as they represent symbolically the “pinkie holds” of young children. We ask the patients if they will let us signal them with a curved pinkie when we think they are detaching. This draws little attention from others, but reminds the signaled patient to pay attention to not detach. Over time patients use the “pinkie tug” to mean a number of things, for example, “I'm here with you, and you are not alone. I care about you. You are doing a good job.” The underlying message is that we are connected. Paying attention is a simple way to teach patients to be more connected in group. We suggest that they keep eye contact with therapists or the person speaking, get

up and walk around, get a cup of water, etc. if they feel themselves beginning to detach.

Kinesthetic awareness exercises can be effective in breaking through the Detached Protector mode in group and they are also helpful as strategies for patients to use outside of sessions. We try out a range of activities designed to increase physical sensation – for example, feeling a smooth cool stone or a rough one, ice cubes, the cold tile under foot, the texture of carpet or fabrics – both rough and smooth. Whatever a patient finds helpful with staying emotionally present can be a tool to use at other times. It is easy to discretely hold a rock or square of fleece in your pocket outside of therapy. We also use physical grounding exercises that increase physical sensation.

### Physical grounding exercises – to help you stay present

Here are some physical focusing exercises to try to help you stay present and not detach. Remember to keep breathing deeply while doing them and to do them *slowly*. All exercises should be done three times for maximum benefit.

1. **Basic grounding:** Stand with your knees slightly bent, breathing deeply and slowly. Extend your arms out in front of you, palms down. Slowly raise your arms over your head and stretch a few seconds. When you feel some vibration, put your chin to your chest and slowly with arms extended bend over until you are completely bent over and your arms are hanging at your sides. Take a deep breath, then slowly start to stand up, letting your arms hang at your sides and be moved slowly by your body's motion. This exercise is like a slow unwinding when done properly. It acts to put your physical body in balance and reduce overall tension.
2. With your back against a wall, bend your knees slightly and breathe. Bend a little more deeply and hold that position until you feel a vibration or trembling in your legs. At that point, come back up. Repeat this two more times.

3. Stand with knees slightly bent. Extend your arms in front of you with palms up. Imagine that you are holding a 27-inch TV set. Feel the stress of holding that TV up. When you feel a slight vibration in your arms, let them drop to your sides, letting gravity pull them down.
4. Repeat exercise 2 with your hands palm down.
5. Repeat exercise 2 with arms held straight out from your sides and palms up. This time imagine you are holding some heavy object.
6. Stand away from the wall this time, with knees slightly bent. Put your chin to your chest and slowly bend over while stretching your arms behind you with palms up. Allow your arms to move up with your body as you bend over. Hold this position until you feel a slight vibration in arms or legs, and then slowly come back to a standing position.
7. Stand with knees slightly bent. Extend your arms up at your sides parallel to the floor. Bend to the side, allowing your right arm to move up in the air as you bend. Hold a few seconds and slowly return to standing. Repeat this with the opposite side arm.

Try to pay attention to the effects of these exercises for you. Do you feel more present and more in touch with your body and your emotions? Do they affect your level of uncomfortable feelings? Reduce or increase your distress level? Do they change your distress level in a positive or negative way? (People's reactions to these exercises vary, but are not usually negative).

One of our colleagues writes mode songs with her group. She chooses songs everyone has heard and the group makes up words for them. The Detached Protector mode song is set to "Leaving on a Jet Plane" (Farrell, Shaw, Foreman & Fuller, 2005). Patients seem to enjoy these anthems of the modes and singing them together in group. This is just another way to bring in play and evoke emotion. A point we want to make is to let yourself use your creativity and allow your Happy Child mode to be present to play. In doing these and any other experiential exercises, the therapist must be genuine in believing in the benefit of the exercise. Patients can think it is silly, but if you think it is silly, it won't work for your group.

Sometimes patients experience the Detached Protector mode as vague feelings of “stuck-ness” without much content or explanation. This feeling of “stuck-ness” at times affects the whole group. Patients say things like “I don’t know why or what it is about, so I cannot do anything about it.”

### Exercise for feeling stuck

Ida has developed a balloon exercise for “stuck-ness”. We validate their awareness and suggest that we start by identifying where in their body they feel stuck. We ask them to focus on questions like, “Does it feel heavy, is it hot or cold, does it affect your breathing, does it interfere with you speaking up, or does it cause you to shut down, does it keep you from getting your needs met?” We discuss the similarities and differences of the “stuck-ness” among the group members. We tell them that we are going to try a technique that will release some feelings of “stuck-ness.” Balloons are handed out and these instructions are given: “I want you all to blow into the balloon some of the stuck-ness from the area we just discussed – however you experienced it – frustration, anger, sadness, pain, tension, etc. Once the balloon is filled up, pinch it off so nothing escapes, but do not tie it. Hold the balloon high over your head and on the count of three, we will all release our balloons. When we do that it is very important that you fill up the empty space with something positive.” The balloons fly around the room making funny noises which causes much laughter. We ask the patients to store an image of this experience to remind them how this simple exercise led to some release of pressure and then filling the space up immediately with something positive (like the group’s laughter) could move the “stuck-ness.” Many patients say that they feel stronger because they could do something about the unpleasant feeling even without figuring out all the “Whys.” We have them keep the balloon to use at home when they are feeling stuck.

### *Behavioral pattern breaking work*

Since the group is a microcosm of the larger world it is an excellent place to practice new behaviors. A significant part of behavioral pattern breaking is actually using the new healthy coping strategies and practicing them repeatedly until they become automatic and begin to replace less healthy

old coping modes such as Detached Protector. This sounds simple, but the schema barriers and feelings of hopelessness and helplessness of BPD patients make this difficult for them. In group we can actively encourage them to apply what we teach them and empathically confront the modes that get in their way. Patients can practice new strategies to remain present using a hierarchy of difficulty that starts with the group and eventually moves to life outside of therapy. In the group there are witnesses to remind a patient of evidence contradicting a schema or mode. For example, “You risked being vulnerable and you were comforted not punished.” This process of cognitive restructuring is translated into “antidotes” with a record that acts as a reminder flashcard. Antidote record examples by mode are available in BEH ANT 1, 4, 5). They have sections for patients to fill out on their own and sections to complete in group. Starting the homework in the session as an exercise helps with compliance as it ensures that the patient understands the assignment thus reducing their anxiety about “doing it wrong.” Any information collected in the mode change stage is recorded in some way to keep it available for reference. This is necessary as the cognitive distortions which maintain schemas (triggers of modes) act to eliminate evidence that is inconsistent with the schema. For example, the cognitive distortion of dichotomous thinking maintains schemas like defectiveness schema. This distortion sees worth or competence as “all or none,” so if any mistake is made you are moved over into the “none” or defective category. This means that positive feedback will not be maintained in memory without measures such as recording it, as it is inconsistent with a strongly held belief (cognitive part of the schema). Fortunately, as patients try healthy ways to get their needs met first in the group and gradually outside of it, their success is also reinforcing of continuing to change.

### **Integrating Awareness, Experiential, Cognitive, and Behavioral Aspects of ST Work**

As discussed in Chapter 5, accomplishing change at the level of schema modes requires the integration of all four types of psychotherapeutic work: awareness, cognitive, experiential, and behavioral pattern breaking.

The following mode role-play illustrates this four-tiered approach. Initially, the role-play elicits emotions and thoughts. The next step is to become aware of and label the emotional experience and identify the need present. This is followed by connecting the emotions to events in the past, examining how that affects the present, and evaluating whether it is effective in getting



the underlying need met. If the answer to the latter is “no” the discussion moves on to what would meet the need and how that behavior could replace the maladaptive coping of the mode.

### Patient example: Integration

A mode role-play was set up in group in which Jenny played her own Detached Protector mode with a group member playing her Healthy Adult mode (with other patients to help as “coaches”). The Healthy Adult mode actor attempted to get Jenny to respond to some questions about what she was feeling. Jenny briefly seemed to be frightened, and then seemed to detach more. The Healthy Adult mode actor could not get through the Detached Protector mode. When we discussed it, an observer commented on the fear she saw briefly. Jenny did not remember this at first, but then was able to recall that brief moment and label it as fear. She reflected on it and told us that when she was questioned by her father as a child, her answers were never correct and the questioning inevitably led to harsh punishment. Now she automatically shuts down (Detached Protector mode) whenever she is questioned by an authority figure. This has led to her losing many jobs as in this mode she is unable to answer even when her supervisor asks simple questions about her work. This Detached Protector mode behavior is misread as incompetence. For Jenny, the role-play elicited feelings that she coped with by flipping into Detached Protector mode, and discussion with the group led to Jenny understanding her pattern of maladaptive coping. Behavioral pattern breaking work was still needed for Jenny to prepare for situations where she would be questioned and could use healthy coping like self-talk to remind her that she will not be harshly punished as an adult; she is not talking to her abusive father, etc. She also planned to practice using her Safe Place image at work daily for overall protection and to pay attention to her breathing when she was answering questions. We practiced this plan in a later mode role-play in group; Jenny was successful in preventing the Detached Protector mode taking over and was able to answer the questions she was asked. Jenny went on to change this behavior in life as a result of the combination of awareness, experiential, cognitive, and behavioral pattern breaking work.

This process of integration must be approached at a speed that matches the patient's experience. We can lead them along and remind them of the pieces, but we cannot push them into it. When we do, we create new problems. For example, a therapist in training grabbed a "patient's" (a therapist role-playing a patient) arm and pulled her down on the floor in an attempt to make her write a faulty childhood message on a parent effigy. She was trying to move her to the next step, recognizing the Punitive Parent mode as "not her." This approach backfired, as the "patient" dug in her heels. She would not write a message and she flipped into Angry Protector mode. In addition, it damaged the limited reparenting bond; she felt abused by the therapist, as she had been by her mother. Patients move at a speed they determine, which we can only facilitate but not control. Making these important connections requires many repetitions. Moments of insight will occur and these need to be recorded for the patient. The pieces will eventually come together with some assistance from the therapist. They cannot be forced together by the therapist or patients will not experience them as their own, and the necessary levels of change (emotional, cognitive, and behavioral) will not take place. A critical emotional learning experience for patients is that when they put aside their default Maladaptive Coping mode in group and allow themselves to be vulnerable (Vulnerable Child mode), the group responds positively and needs are met, rather than the negative or absent response and/or punishment they received in childhood. They can identify other safe places and people to be vulnerable with in steps and also learn to protect their Vulnerable Child mode with their Healthy Adult mode if it is necessary. They become able to risk vulnerability more often in interpersonal relationships, allowing them to grow and deepen.

We summarize the cognitive, experiential and behavioral mode change work for patients with a plan for each area of intervention in an "antidote chart" (BEH ANT 1 to 5 are record forms). We use the metaphor of Early maladaptive schemas and MS Coping modes being "poison" and the interventions used and tools patients develop are antidotes. An example of a summary antidote form for Detached Protector is shown in Table 7.2 and BEH ANT 1.

## **The Vulnerable Child mode**

Once coping modes can be dealt with and/or put aside, foundation safety is in place, and the Vulnerable Child mode can be reached in group sessions, healing work for the "little child" part of patients becomes the focus.

**Table 7.2 Antidotes for the “poison” of Maladaptive Coping modes**

<i>Mode, feelings, need</i>	<i>Cognitive antidote – reality check</i>	<i>Emotional antidote – image or memory</i>	<i>Behavioral antidote – soothing strategy</i>
<b>Detached Protector</b>	<i>Read over the information sheet on this mode and the pro and con list that I completed. Those things remind me that I don't have to use this “big gun” to protect myself today, I am no longer a helpless child.</i>	<i>Go to my Safe Place image and revisit the image of all of the group members as little children coming to the park to play with me. Remember also how they drove that bully away who bothered me the whole school year. It feels great to feel as if someone has my back.</i>	<i>Write down some things to remember on flashcards and read them over daily. Draw a picture of me and the group on the playground and put it up on my refrigerator.</i>
<i>Feelings – scared, overwhelmed</i>			
<i>Need: safety</i>			

*Awareness work*

The same series of steps are used for the Vulnerable Child mode as for the Maladaptive Coping modes. Patients read handouts on the mode, complete questionnaires about their experience of the Vulnerable Child mode and what they know about him or her, and all of that material is discussed in the group. An example of the Mode Awareness Monitor for the Vulnerable Child mode is provided in patient record form AW 2-2, and AW 2-5 is a blank monitor form.

The homework assignment shown here for the Vulnerable Child mode addresses safety in a broad manner.

**Meeting Vulnerable Child mode needs: safety,  
nurturance, and comfort**

Fill in what your Vulnerable Child mode has and is able to use for safety, nurturance, or comfort.

1. Physical safe places in the present?
2. Safe place images from the past that you can use now (e.g., “grandma’s house”)?
3. Contact with safe/supportive people (e.g., hugs, being held)?
4. Pictures of safe nurturing people?
5. Safe/soothing objects (blanket, stuffed animal, etc.)?
6. Symbols of safety?
7. How can you use these to make the group safer for Vulnerable Child mode?
8. Write about your use of these various safety options to discuss in group. (VCM 2).

*Cognitive interventions for Vulnerable Child mode* Cognitive interventions for the Vulnerable Child mode consist of education and cognitive restructuring. We review and expand upon the information first presented in Stage One (Chapter 6) about what all little children need and deserve growing up, what our patients did and did not get of those needs, and what unmet needs remain in the little child part of them today affecting their behavior. By this session the group will be comfortable enough to share more information about their childhood. This is a time to go back to the

“Mode Origins” Exercise presented in Chapter 6 to apply it to additional feelings and needs (Handout ED ST 4) Cognitive restructuring focuses on patients re-attributing the source of their current problems to the inadequacy of their childhood and adolescent environments, rather than to an inadequacy or flaw in them. This work focuses on changing the labels for self that reflect the beliefs of the Punitive Parent modes, for example: “I am bad,” “I am too needy,” “and Daddy left us because of me.” This is one of the times where it is clear that the cognitive and emotional levels are fairly independent as patients can fairly easily understand and even accept changed labels intellectually, but not yet feel the change. The experiential work with this mode is required for the emotional level to change and the Vulnerable Child part of patients to heal.

The cognitive component of Vulnerable Child mode work needs to be in a form that matches a child’s level of cognitive development to be effective. The “Good Parent” Script exercise in the next section is an example of a verbal intervention designed for a child to understand. Messages are worded in a simple way. For example, “You are a great kid,” “I love you, and you are precious.”

### Therapist Tip: Match developmental level

In all work with the Vulnerable Child mode, consider the emotional and cognitive development of patients’ little child part and focus your interventions accordingly. Ida is really good at engaging the child modes by accurately addressing the level of development patients are at when in these modes. Some observers have remarked that she can sound like a “kindergarten teacher.” That is what she is intentionally attempting to match, so that she reaches the Vulnerable Child mode. We think that it is possible once you have a good connection with a patient to almost “see through” to the Vulnerable Child mode, especially when doing experiential work. We use this as a rough guide for what level to pitch our verbal interactions at. It is important to avoid treating a patient in the Healthy Adult mode like a child or one in a child mode like an adult. Being able to distinguish the two is one of the challenges of any ST – individual or group. A rule of thumb here is that you can always ask what the mode is if you are in doubt.

We use an intervention that combines cognitive and experiential work to function as an early step in imagery change work. We were having difficulty

with fear in one of our groups about trying imagery change work, so we decided to begin with literally rewriting a memory. As usual, we gave them an extensive example and discussed it in group before asking them to try one. We chose an example situation that was a difficult experience, but not traumatic. What follows is the example they were given and instructions for rewriting a similar memory of their own.

### Example: Rewriting memories

Here is an example of how experience in childhood related to needs, sets up schemas that influence our adult lives. One of Patty's main schemas is **abandonment**. This schema developed because in childhood whenever Patty made a mistake, her mother gave her the cold shoulder and even stopped talking to her for days. When this happened, most of Patty's needs were not met – safety, stable base, predictability, love, nurturance and attention, acceptance and praise, empathy, guidance and protection, validation of feelings and needs. When Patty makes a mistake today, she feels her mother's cold shoulder. She has coped with this by avoiding making mistakes, so she never tries new things and her life is very narrow. If she ever does make a mistake she withdraws and avoids the situation. Often it is this withdrawal, not the mistake itself that leads to her being alone and feeling abandoned and lonely. She does not always remember the memory of her mother's reaction – but she has the feelings that went along with it replayed. Sometimes if she has made a mistake she tries to protect herself by acting angrily or coldly toward the person she thinks will be mad at her. When she does this it hurts her relationships. People think, "What is wrong with her? She made the mistake and that is no big deal, but I don't like the way she is acting toward me."

**Patty's core memory:** "When I was 8 years old my mother was in bed with a migraine. I decided to try to bake some cookies like I did at Grandma's house. I got the recipe wrong – I used a pound of butter for six cookies and they tasted awful. When mom got up and saw the cookies, she was furious. I used the oven without permission and I wasted all those expensive ingredients. She said I was hopeless and couldn't do anything right. Mom went back to bed. My father was working, so I was alone all night and had no supper. The next

day mom still wasn't talking to me and gave me really mean looks whenever she was in the same room. She acted like I was invisible for days. Mom did the same thing a lot whenever I did something bad.

Here is an example of how the memory could be rewritten as it should have happened.

"I tried to bake some cookies after staying with grandma. Mom was in bed with a migraine. Somehow the cookies just didn't turn out right. When mom got up she was mad at me for wasting ingredients and using the stove. She went back to bed and locked her bedroom door. At that moment the doorbell rang and Grandma was here. I told her what happened and she hugged and comforted me. She said that it was no big deal that the cookies didn't turn out, I didn't have her recipe. She said she would write down the recipe and I could try it myself at her house – that I was adventuresome and a smart little girl. She said that mom was probably in pain and crabby, but that she should not have been so mean to me. Grandma said that everyone makes mistakes and that is how we learn things. She took me to the store to buy the ingredients I had used so mom would not be so mad. When we got home mom was up and Grandma talked to her about the cookies. She stuck up for me – she said, "Patty is only eight. Nothing bad happened. She has to be able to try things on her own and no harm was done. It isn't right for you to ignore her and be so mean." Mom gave in finally and agreed with Grandma. Grandma stayed and made dinner for both of us. Mom didn't hold a grudge."

**Instructions:** In your rewritten memory you can bring either or both of us into the scene to advocate for you and meet your needs, or another adult (e.g. a grandma). We are happy for you to use any of us. Don't worry if it seems silly at first. We know that this technique works and we will work together in group to make your new script even stronger. (EXP 5: Homework form: Rewriting schema-related childhood memories.)

Taking the first step in written form made it possible for our group to start doing imagery work. It seemed to help them understand the process better, make it less vague and frightening, and reduced their fear that they would fail or be overwhelmed. We remind the group that we cannot change the initial event where their need was not met, nor erase the

pain they experience about that, but changing the ending can give them a new memory of what should have happened and a feeling of power over the memory. It can also correct the conclusion they reached as a child that they were too needy or bad in some way and that is why the painful event happened. They can *feel*, as well as *know* that they were an innocent child who deserved to have his or her feelings heard and needs met.

*Experiential interventions for Vulnerable Child mode*    **Imagery work** is the major experiential intervention of ST for healing the Vulnerable Child. As described earlier (Chapter 6), we pave the way for more difficult imagery with the early “fun” images and safety images. The safety images remain important tools throughout psychotherapy and as a healthy coping tool for use in life. Patients must be able to use safety images to stay present when they become aware of the feelings of their Vulnerable Child mode in order to participate in imagery change work. In imagery change work patients access their Vulnerable Child and go in imagery to a childhood scene where a core need was not met. They allow the therapist, and later the group also, to enter the image to meet the need. This usually takes the form of protecting the child, comforting him/her, telling the Punitive Parent mode to stop, that they were wrong to treat him/her like that, and then taking the child in imagery to a safe place. The group is brought into imagery change work in a variety of ways and at different depths of involvement.

It is important to give patients a rationale in understandable language for why we do imagery work, and how it works, so that they can be open to trying it. They are usually more familiar and comfortable with cognitive interventions. Often this is also true for their therapists. What follows is the rationale that we begin with. We do not deliver it like a lecture. We weave in questions patients have, ask them questions related to it and pay attention to whether it looks like they are taking the information in or detaching. If the latter, we stop and do an exercise to increase their emotional presence like the grounding exercises, which we use regularly to get through modes such as Detached Protector.

Imagery and imagery change work or rescripting are central experiential interventions of ST, which have the same role in GST. We think it is important to give patients an understandable rationale for the work so that they can be full collaborators in it. We show here some of our rationale for them.



### Rationale for Imagery Change Work

*We explain to patients why we do imagery change work as part of ST and how it works*

“Our memories of childhood are not happening right now, rather they are images that we have stored of perceptions, feelings, sights, sounds, and thoughts that we have connected with childhood events. Even though they are not “real” in the sense of “happening right now,” when we bring them to mind *it can feel like they are happening now* and it causes emotional pain. In imagery we can change the ending of painful memories by creating in your image *what should have happened*, if the protective, strong “Good Parent” you deserved had been there. Just as we all can re-experience pain and fear when negative childhood memories recur, we can also experience comfort, protection, and care when we bring the “new ending” into our mind in imagery. The mind works like a slide projector that puts one image at a time on the screen of our awareness. In imagery change work, we are changing the slide you put in the projector for that particular situation. This may sound like magic, but it is supported by scientific research. Imagery change work is an effective way for people to heal from traumatic childhood memories. Experiencing our rewritten memories of having loving, protective parents affects how we think about ourselves. One of the most important things we take away from events is *what we think it means about us* that the event happened. So if we are not protected and bad things happen to us as children, the Vulnerable Child part of us interprets that to mean that we are bad. As children we are not capable of understanding like an adult can, that the real problem is not that we are bad – the problem is that *no one was there for us*. We had the normal needs of a kid, but no one was there to meet them. Unfortunately, every time you remember these painful childhood events, the feeling of being bad comes along too. That means that years of practice have made it very strong and you don’t question it anymore.

We have been questioning the assumptions you made about yourself as a kid in our cognitive mode work. We have looked at how we form beliefs about ourselves, others, and life based on how our needs were met, and then we don’t question them – they are our

reality. Some of you have reached the point where you are beginning to be able to say, “In my head I know that I am not bad or evil, I was just a kid with normal kid needs.” However, we have also talked about how you still *feel like you are bad* in some way. That is the part we can work on in imagery. The idea that you *still feel* unworthy, bad, a failure, too needy, or whatever messages you internalized.

Our goal now is to give your Vulnerable Child part a good parent to protect, comfort, nurture, love, teach, and all those things kids need. We will approach this work in small steps as we do not want you to feel overwhelmed or re-experience bad memories again. We want to stop painful memories *before anything bad happens*. We want to rewrite the ending, so that nothing bad happens in the image. We also want to teach you how to stop re-experiencing bad memories when they start up outside of therapy.

### *Beginning imagery work for Vulnerable Child mode*

Safety is critical to doing mode work with the Vulnerable Child mode. Ways to establish safety in the group have already been discussed in Chapters 4 and 6. The “Ice Cream store” imagery has demonstrated to patients that they are able to manage imagery. We begin Vulnerable Child mode work sessions with the Safe Place image and concretely assess any unmet safety needs. We encourage patients to bring personal soothing objects, like soft shawls, stuffed animals, and transitional objects, with them to group. We also keep soothing, comforting items in the group room that they can share (REF 7, Group Therapist Tool Kit). In sessions where we access the Vulnerable Child mode, therapists pay particular attention to using a warm, caring tone of voice and to provide comfort, including hugs if requested or if permission is given (see section on physical touch in Chapter 4 for a discussion of boundaries).

As the Maladaptive Coping modes are put aside, the “little child’s” voice can be heard and her needs expressed. We encourage patients to ask for needs such as comfort to be met and we work to develop a culture in which all needs for comforting are accepted and welcomed.

### Example: the Safe Group

An example of this environment comes from a group of ours that had just added new members and was discussing Safe Place images before doing the opening exercise with them. One of the new patients said that she had “never felt safe.” Other members were reassuring to her saying things like, “I hadn’t either before I worked on it in group,” etc. One of them suggested she use a pillow to hold over her heart. She accepted it, so one of the mentors said, “Pillow up everyone” and they all began laughing at this, picking up pillows, and discussing who needed what size and type of pillow until everyone had what they needed. This response from the group was very reassuring to the new members. It allowed them to feel safe enough to participate in the imagery. They were also successful in imagining a Safe Place – one of them even chose the group room.

In the beginning of mode change work, therapists and other patients can help identify needs in the Vulnerable Child that are apparent to them as observers, but unrecognized or not put into words by the little child of the patient experiencing them (e.g., “You look sad, would you like a hug?”). Patients are usually quite willing, by this point in group, to offer comfort to each other – a hug, sitting nearby, holding a hand or a pinkie, a cup of water, a blanket, the loan of a soothing object, etc. The therapist is always the “back-up” comforter, as we try to avoid a patient in Vulnerable Child mode asking for a need in an appropriate way (i.e., with words not unhealthy actions) and not getting a positive response. We also do not want patients to feel they must surrender to the need of another rather than taking care of themselves. It is very important that any limits set by patients in the Vulnerable Child mode be honored. We would never push comfort on a patient who is feeling frightened or just does not want that contact. This issue is covered in the ground rules on touch. There will be times when a patient is not available to a fellow patient for a hug, and even times when the response to such a request is somewhat harsh. It is important for therapists to step in on those occasions to help one patient deal with hearing “no” and the other not flip into Punitive Parent mode for saying “no.” “Boundaries” is a topic that is regularly brought up for discussion in groups.

Once a safe base has been established, we introduce imagery in graduated steps matching the pace of the patients. We begin with the goal of just reaching the Vulnerable Child mode. Often patients have had some connection with their Vulnerable Child mode during the Safe Place image work. As the instructions later in the chapter illustrate, we keep early imagery short to desensitize patients to connecting with a mode that is a frightened and often disowned or rejected part of themselves. At first we just want them to be able to see or be aware of the Vulnerable Child mode in imagery. Next we move to imagery in which they connect with the Vulnerable Child mode and experience the feelings and needs of the mode. The next step is imagery change work. This work also progresses in stages in terms of who is in the “good parent” role – therapist or the patient’s Healthy Adult mode.

Imagery change work in ST allows us to meet the Vulnerable Child mode in the patient’s childhood memory and rewrite the ending in such a way that the core need is met. We begin with situations in which the little child needed something and no one was there to give it to them. The patient is feeling the original pain that is in a sense frozen in the Vulnerable Child mode, and with imagery we have the opportunity to create a new experience and a new memory. Eventually the childhood memories weaken as the patient has the experience of having core needs met. Patients begin to feel as well as understand the legitimacy of their little child’s needs and the “goodness” of that part of them. They know this is what should have happened in childhood and can happen now in psychotherapy. They experience that childhood wounds can heal. The Vulnerable Child mode may always have some schema triggers related to abandonment, emotional deprivation, and punishment, but the healing attachments that were not made back then can still be made now, thanks to the brain’s amazing plasticity.

We do not begin to talk about the Healthy Adult mode aspects of meeting patients’ needs until well after they have experienced feelings of protection, comfort, validation, acceptance and love in the safety of imagery, and the experience of the group’s healthy family environment. Only after this missed step in attachment and emotional development has been accomplished, and a “good parent” has been internalized, are patients able to meet their own Vulnerable Child mode needs in a meaningful way. In our early work with BPD patients we made the mistake of attempting to move directly to teaching them soothing skills. We found repeatedly that they could not use them until this deeper level of mode change was

accomplished. The distinction about who comes into imagery work to change the scene (e.g., to protect the child) is a very important one. Cognitive therapy approaches (e.g., DBT; Linehan, 1993) assume a “healthy adult” already present in the patient and pull for self-care from the patient from the beginning of this work. As delineated here, that is not the approach of ST whether individual or group. The modeling of a Healthy Adult and a “good parent” to the Vulnerable Child by the therapist and the internalization that occurs in limited reparenting and imagery work are critical steps unique to ST that allow the development of a Healthy Adult mode in BPD patients.

What follows is the series of progressive imagery and imagery change exercises that we have developed for use in GST with therapist instructions. In this process we are correcting information that patients have regarding childhood needs, but more importantly we are providing them with corrective emotional experiences that allow them to heal residual trauma and eventually internalize the “good parent” figure provided by the therapists.

We use two primary versions of imagery change work in GST: group as a whole, and individual to group. We begin with group as a whole work in which we move from the therapist meeting the Vulnerable Child mode needs to the patients using their “good parent” with support, then to their Healthy Adult mode eventually performing this function. All the patients go into their own image with their Vulnerable Child mode and the therapists describe going into all of the images at once to meet Vulnerable Child mode needs. After the imagery work, the group shares what they experienced and discusses how effective it was in meeting their Vulnerable Child mode needs. In individual to group imagery work, we move from a group image into the individual image of a patient. In this form there are a number of different ways to bring the rest of the group into the work. Individual to group imagery change work is the place where traumatic experiences that are specific to an individual patient are worked with.

### *Step 1: Imagery to access the Vulnerable Child mode*

*Connect with your Vulnerable Child mode* We begin imagery work with instructions to just see and begin to learn about their Vulnerable Child mode. The therapist not leading the exercise should be alert to signs of distress in order to provide verbal reassurance like “You are doing a good job.”

### Introductory Imagery instructions

1. After asking the group to close their eyes or look down and visit their Safe Place image, we start out with a short and simple image that will take 3–5 minutes total: “Get a picture of yourself as a little child. Really zoom in on what your little child looks like, what is he/she doing? What expression is on his/her face? What might she be feeling?” We have them come back to the group to discuss the experience.
2. “Get a picture of your little child when he/she felt safe for the first time. It may have been with your grandmother, or up in a tree, or riding your bike, or at school, just anywhere your little child felt safe. What does your little child look like? What is he/she doing? What expression is on his/her face? What might he/she be feeling?” Again, after 3–5 minutes, come back to the group to discuss. We ask about the experience and encourage as much discussion and sharing of experiences as possible. We use the same questions to build predictability and safety. The goal of these first images is just to get them to look at the Vulnerable Child and experience being able to do this without an overwhelming negative result.
3. Next we use an image with play in it, for example, the “winning an ice cream cone,” image but let it be their little child who gets to choose and eat the ice cream

Patients’ responses to these exercises can be quite variable. We try to keep the time short and the images simple and structured, however it is possible that someone could go immediately to a traumatic experience. If that happens, you can bring them back to the present, get them to look at you, if needed get up and walk to feel more grounded in their body, etc. You can explain that we will later take on those traumatic memories too, but we need to build up to them. Some patients will have more difficulty getting an image. That can be discussed and other patients asked how they are able to accomplish this. Often patients can give very good suggestions to each other about how to get images. We suggest looking at a picture if they have one or imagining a movie or just listening to the words of description and

not trying to make anything happen, just be open to the description. We want to be validating of everyone's effort to avoid those who have difficulty feeling like failures. "You all did a good job and were courageous because you sat here and tried to stay with it or did stay with it," "This is something that can take time to work on."

Unfortunately, patients with BPD do not deliberately connect with their Vulnerable Child mode very willingly. They typically have negative and rejecting feelings toward their little child part that need to be addressed.

### Therapist Tip: Negative feelings toward Vulnerable Child

Inevitably someone asks, "Why do we have to do this?" or says "I hate that kid, he was the source of all my problems, he was a bad kid." Our answer to the first question is always some version of "We need to do this because the only way to get unstuck emotionally and not keep living with the consequences of not getting core emotional needs met (use their words: how you were mistreated – neglected, abandoned, etc.) as a child is to go back to that time experientially and help that part of you heal and get his/her needs met." To the second question we say for example, "It was not your fault as a little child that your needs were not met. Young children are not 'bad' if they are getting their healthy normal emotional needs met" or "Is that how you feel about the Vulnerable Child mode of your peers here?" Often the answer is no, which allows us to say, "Your little child is just as worthy of love and care as the rest of us. I think that we are hearing a Punitive Parent mode voice right now and we will not allow any Punitive Parent modes here when we are working with Vulnerable Child modes. We need to get those Punitive Parent mode statements out of here."

*The little child on the street* The next imagery exercise is one that we use both to assess the relationship between the patient and his/her Vulnerable Child mode and to develop some compassion for the Vulnerable Child mode.

### Little child on the street image

Ask patients to try to see or imagine what you will describe to them (If your group has both genders substitute he/she).

1. "You are walking down the street toward your home and you see a small child ahead of you. Your first reaction is that she is too young to be out alone, only 3 or 4 years old. As you get closer to the little child you notice she is crying and hanging her head down. When she sees you, she keeps her head down, but raises a hand up to you in an imploring way."
2. "You take her little hand and start telling her reassuring things – like you will find her mom, you are safe, etc."
3. "You decide to take her home with you so you can give her some milk and cookies and call for help locate her family. She very willingly goes along with you holding your hand."
4. "As you near your house she reaches both arms up to you to be picked up. You pick her up and as you get a first look at her face you realize that it is you as a little child."
5. "How do you feel? What do you do? How can you continue to try to take care of her?"

This exercise can be quite emotionally evocative and give you information about how much or little compassion the patient has for their Vulnerable Child mode. A number of our patients told us that as soon as they realized that they were the child, they wanted nothing to do with him/her. A few patients even reported that they had dropped the child. Many patients have similar negative reactions. Some were able to continue taking the child home, but then said, "Since it is me, I do not know what to do with her." Interestingly, this is not due to a skills deficit, rather a discrimination error in not matching caretaking skills they use with others to their own need. These responses provide openings to introduce the idea of compassion for the little child they were who did not get needs met and who needed love and comfort as much as the little child on the street. Barriers to self-compassion can be identified – like faulty beliefs that their child is "bad," "undeserving of love," etc. At the cognitive level, the group can discuss whether a young child deserves having needs met and which needs, how a young innocent



child becomes “bad” in their eyes, and related topics. It can be useful to do the exercise again with the patients knowing it will be their child, with instructions to try to comfort and take care of the child like they would a real child of their own or a beloved niece or nephew or grandchild.

### *Step 2: Imagery change work*

*The Good Parent script* An exercise which we use regularly, to support our limited reparenting stance is the “good parent script.” We start with a homework assignment that has the patient write down what they would like to have heard from a loving parent as a child. We point out that the language should be young child level (e.g., “I love you just the way you are,” “You are precious to me,” “I am so glad you are my kid,” “You are a really great kid,” “I will always be here for you,” “I will protect you.”) They bring their list into group and we discuss it. We get their permission for the group to borrow ideas and statements from each other, as invariably some will say that they could not come up with anything. While patients are sharing their choices, the therapist is recording them to construct a collective “good parent” script.

#### “Good Parent script” exercise

1. “Go to your Safe Place image and connect with your Vulnerable Child mode. Let him/her be in the Safe Place and know that no one can hurt them. I am also going to put a Safety Bubble around the whole group. Remember that we promise to keep you safe here in the group. We will not let bad things happen to you here.
2. I want to tell you some of the things that you should have been told by your parents and people taking care of you in childhood. I really want your Vulnerable Child mode to hear these things as they are things that all little children need to hear.”

Then one of us reads the script in as warm, soft, and caring a voice as possible. We add in some of our own good parent messages. It is particularly important for the therapist who is not reading the script to add a number of statements.

3. “I want you to really hear me and be open to taking these statements in. If you get interference from any parent modes try to kick them out, tell them they are not allowed here – only good parents can come in our group space. Try to remember the things you are hearing that you like best, because we are going to do something special with them. If you have trouble remembering, don’t worry, I have it written down and will help you remember.”

When the script is finished:

4. “Come back slowly to the group, remembering what you liked. We will discuss what that was like for you, whether you could take it in from your Vulnerable Child mode, the things that you heard that you liked best, any surprises, anything you had trouble with (EXP 2: form).

The group discusses the experience, how they felt, whether they could stay in their Vulnerable Child mode, what did they like best, etc. You can give patients an audiotape and/or a written copy of the script to listen to, re-read and carry with them. **Homework** after this session is to do something once a day to remember the experience of listening to the good parent script. Transitional objects are given to remind the Vulnerable Child mode of her connection with the “good parent” therapist. We use objects such as a soft piece of fleece, with or without a scent the therapists use, a special bead from each therapist on a piece of cord, or a note with their good parent message on it. The “good parent script” and other messages to the Vulnerable Child mode can be made into flash cards, poems, songs, drawings, or any other transitional object that is tangible and can be available outside of therapy. In our groups when we discuss the results of the homework assignment, patients often report that they re-experience the exercise by actually hearing our voices again, which illustrates the internalization resulting from this therapeutic work with the Vulnerable Child mode.

*Step 3: Imagery change work: rewriting endings for the group as a whole*

*Beginning slowly and safely: therapist Vulnerable Child mode imagery* We begin imagery change work gradually by having patients hear a memory where a good parent was needed from the therapist’s childhood. First they are asked to watch this scene happening to the Vulnerable Child of the

therapist. Second, they are asked to try to put themselves in the place of the therapist's Vulnerable Child mode. Using self-disclosure in this way indicates the level of emotional difficulty of situations that we begin with, allows patients some distance at first in imagining a childhood situation in which someone else's Vulnerable Child mode has unmet needs, and facilitates patient self-disclosure. It reduces apprehension by providing an example of how we do imagery rescripting. It also demonstrates that we all have modes and it can make the therapist seem more real and genuine, thus fostering the connection with her.

### Exercise: Good Parent figures for Vulnerable Child mode

#### *Therapist self-disclosure example*

1. "Connect with your Safe Place image. We will stay there for 1–2 minutes. I want you to remember that your Safe Place image is there for you and you can return to it any time you want to in the session today."
2. "I am going to tell you about a time in my childhood when I needed a good parent and no one was there to fill that role for my Vulnerable Child mode. What I would like you to do is imagine yourself outside of a store looking in through a big picture window that allows you to see everything that happens inside. I was 6 years old, in a little souvenir store picking out my souvenir from the family vacation. I really looked forward to that because I collected souvenirs. I found a snow globe that was within my dollar budget, but when I picked it up it was slippery and I dropped it. It smashed and splattered everywhere. The store owner yelled at me and made me pay for it with the one dollar I had. My mother was there and did nothing to help or defend me. I was devastated, but didn't cry because we were with my uncle and my cousins and I was embarrassed. I felt like a bad kid. I also felt like I would be all alone if I got into any trouble."

Group discussion has patients sharing what they experienced and what they think the therapist's Vulnerable Child mode felt. We ask them questions like: "What do you think my little child felt and what

did she need to hear? What could my mother have done differently?" Encourage them to ask any questions they have about the experience.

3. The second therapist leads this part of the imagery work. Ida begins by asking the group, "How can we work together as a group to change the ending now?" After a new ending has been brainstormed, we set the image up, modeling what we will ask them to do in their imagery work.
4. Ida says: "Now, Joan can you go back into the image and connect with little Joni and the rest of us will join you? I am going to play the good parent that Joni needed and I want the rest of you *in the image* to watch and see how me using our script affects little Joni. Look at what happens to the little child's face when I, as a good parent, defend and comfort her."
5. The lead therapist then sets the scene as just after the snow globe smashes, and she plays her role dramatically.

To the Vulnerable Child mode: "Oh, Joni honey are you alright? Let me get you away from this broken glass. Poor baby, are you hurt anywhere? Don't worry you are not in trouble – it was an accident."

To the shopkeeper firmly: "Stop – do not yell at this little girl! Can't you see that she is upset, she is a child and you have no right to yell at her? Talk to me about this. I am the adult and will be responsible for any damages."

To Vulnerable Child mode: "It's okay dear, you didn't do anything wrong, it was an accident. I know that you really wanted a snow globe, I think they are pretty too."

To the shopkeeper: "Here is \$2.00. One dollar for the broken one and one for the new one you are going to bring out for little Joni." The shopkeeper pulls a new one out from under the display – and it slips out of her hands and breaks. Ida says to Joni, "See, all of us can have accidents." To the shopkeeper, "I hope that you have another one, but if not there are a lot of other stores here."

The group and therapists come out of the image and discuss what they observed. This is an opportunity to underline how a good parent would act and the very different effects when Ida played the good parent. We point out that the incident is one that Joan still remembers vividly, because her normal

childhood needs in the situation were not met. This could be followed by a repeat of the imagery with the instructions to the patients: “Try to put yourself in my Vulnerable Child’s shoes and imagine how your Vulnerable Child would have felt and what he/she would have done and who would have been there for you.” This would be done for the original memory and the rewritten imagery.

*Rewriting endings for patient’s Vulnerable Child with therapist acting as a Good Parent figure* Again we use images of progressive emotional difficulty. We start with a short image that introduces the therapist entering the image with the patient observing the interaction with the Vulnerable Child mode.

### Imagery exercise

#### *Introducing the therapist as a Good Parent figure, patient observes*

1. Ask them to imagine their little child and you go into the image. “Now I want you to get a picture of your little child and he/she is alone and sad and even scared. Imagine me coming into your image to comfort and protect your little child. Just listen to what I say to your little child – “I am here so you don’t have to be scared. I’ll protect you. No little child should be left alone like this. You are precious and deserve protection.”

The next image moves to the patient being connected with the Vulnerable Child mode.

#### *Therapist as Good Parent, patient connects with Vulnerable Child mode*

1. “So now you can see the little child part of you. He/she is sitting in the family den or living room sitting alone playing with a toy. Take a look at your child’s face and see what you can discover about how he/she is feeling. Just register the feelings and try to be there with that part of you. Try to be aware of what your little child needs. Is he/she hungry, cold, sad? Does he/she need comfort, protection, a hug, to feel loved (ask about the core needs)?”
2. “Now imagine me coming into the image to meet whatever your little child needs. Whatever your child’s needs are, I am meeting

them. Try to just take in that experience of having your needs met in your little child part. Know that I will ask nothing in return, there is no price tag. You are a young child who needs some care, deserves to have his/her needs met, and I am giving that to you.”

Here we are making the *transition to them being the child*, not just seeing him/her.

*Rewriting endings for patients’ childhood memories using the therapist memory format*

Patient experience of needing Good Parent image

1. “Okay, I want you to go back to a time in childhood where you are in a situation as your Vulnerable Child mode where you wish you had a Good Parent to intervene and protect you. Just focus on whatever comes to mind as a time when you really needed a good parent to be there for you.”

Judging by their nonverbal behavior, we let the group go for 2 minutes or stop sooner if there is too much overt distress. In this early work we want patients to realize that they can visit uncomfortable memories without becoming completely overwhelmed and suicidal, so we keep it short.

2. “Now open your eyes and come back to the group and let’s talk about what you were aware of.”

If a patient responds to the question, we go with it. If they are silent, use an example of your own. Use something like the snow globe example from your life. The example from Joan is about the level of severity that we would share. We try to get everyone to share something from their experience. If someone does not come up with one, suggest they may think of one as we talk more and they should feel free to add a memory later.

3. Next we go back to the uncomfortable image. If someone has brought up abuse or trauma have them go back to the point before anything really bad happened.

“Okay, go back to that image just for a minute or two and be aware of what you need as a Vulnerable Child mode in that situation.”

Have them again come back to the group. This is good practice in asking for needs directly. Also it ensures that we will know what needs to meet in their imagery when we go into it as the Good Parent figures.

4. “So now briefly tell us about your image. Who was there? How old were you, etc.? What were your needs?” We encourage them at this point to continue using “I” language.
5. Ask them to “Go back now to that same image as your Vulnerable Child mode. Be your Vulnerable Child mode.”

*Vulnerable Child mode image to begin the group session – use as practice*

In leading the group opening safety image, the therapist can interject speaking to the patient’s “little child” about the safety measures she/he has taken in the group and pledge to protect her. The therapist could read a “Good Parent script” constructed previously by the group of what their Vulnerable Child mode needed to hear in childhood. This gives the group additional exposure to the Vulnerable Child mode being present and safe.

*Progression in imagery of the Good Parent figure from therapist to the patient’s Healthy Adult mode* The next imagery exercises represent the series of steps we go through to move from the therapist in the role of Good Parent figure to the patient’s Healthy Adult mode acting as a good parent to his/her Vulnerable Child mode. Keep in mind that the last step will occur in the second year of GST.

### 1: Therapist as Good Parent

- “I am going to come into your image as a Good Parent figure to make sure that all of your needs are met. I want to validate you,

protect you, and give you what you need.” We use as many details as possible from what the patients have described.

- We go on talking to the group in imagery, for example, “For Little Kate and Ben, I won’t let your mother hit you – I will grab her arm and send her out of the house and take you away to somewhere safe. For Little Jane and Ann, I will give you a nice plate of food and send your mother to bed without supper, etc.” making sure that you have remembered everyone.
- “Now open your eyes and come back to the group and let’s talk about what you experienced.”

We would typically use the therapist as Good Parent a few times before moving to the Good Parent of the patient meeting their Vulnerable Child mode needs.

## 2: Patient as Good Parent

This would be done much later in sessions.

Have the patient model you from their Good Parent. We use this idea of a Good Parent part of them (actually a part of their Healthy Adult mode) as a step in between our Good Parent and their Healthy Adult mode. Usually patients with BPD have some child in their lives they care about and usually love intensely. Leading up to this imagery, we would discuss how they treat little children they care about and even treasure. We ask what they would do if that little child was being hurt, and they have immediate and strong protective reactions. When we follow that with “And if it was the little child part of you?” we get a very different reaction; they have little compassion, criticize that child, and say, “It is different.” So we ask them as an exercise to do one of the following for the child in their image from their Good Parent either:

- “Come into the image with me and watch what I do for your little Vulnerable Child mode” or



- “Go into the image and do for your little child what I did, from your Good Parent. I will be there watching and supporting you, helping you if needed.”

The occasional patient says that they have “no Good Parent in them.” We have those patients come into the image to watch us being Good Parent again and suggest that they watch exactly what we do so that they can begin to build their Good Parent. We see a patient’s Good Parent as a representation of any good parenting they received through their life, whomever it came from, including past therapists and what they are getting from us in limited reparenting. What we are calling their Good Parent is part of their Healthy Adult mode. However, from experience, we find that it is too early at this stage to talk to them about their Healthy Adult mode directly as that concept seems to still trigger too many Early Maladaptive schemas head on. Presenting the idea that they have an internal Good Parent for some reason is easier for them to accept. Maybe because they do use that part of themselves for chronological children in their lives or it is a level of abstraction that their Punitive Parent mode does not catch. We have found that this gradual approach to building a Healthy Adult mode for them, which has a Good Parent, seems to sneak past the Punitive Parent mode. It may also be that discussion of Healthy Adult mode brings up fears of “getting better” and being abandoned or losing the therapists as Good Parents to their Vulnerable Child mode, and adding a Good Parent in them does not. This may be another example of our patients training us over the years to be sensitive to the words and concepts that are easier for them to take in.

3. Healthy Adult mode is present alongside the therapist who is taking the protective and nurturing action.
4. Healthy Adult mode there able to care for and protect the Vulnerable Child mode, therapist observes and validates their Healthy Adult mode.
5. Healthy Adult mode independently cares for and protects their Vulnerable Child mode

After each image, we process the experience as a group. This processing is an integration of the cognitive and experiential aspects of the

imagery change work. The therapist pulls out themes to support the overall idea that the child was mistreated, did not deserve that treatment, was not bad, the parent was wrong to treat a child so harshly, etc. As Homework we ask them to write out what the Good Parent said or did for the Vulnerable Child mode that they liked, or draw the image, collage, or whatever visual form appeals to them. Then we want them to practice returning to that scene in which the needs of their Vulnerable Child mode are met, with the task of just taking that experience in. We start the next group with a discussion of how their practice went and fix any “bugs” that occurred in their practice. We tell them that it takes time and repetitions for imagery change work to have an impact as it needs to counteract many unhealthy experiences.

*Responding to traumatic material or extreme distress* If disruptive traumatic material comes up before the group is established and bonded enough to contain and work with that content, a number of interventions are possible. However, patients (and therapists) can be reassured that the Vulnerable Child mode will not feel more than can be tolerated, as when that overwhelmed point is reached their default Maladaptive Coping mode will take over.

### Therapist Tip: for trauma re-experiencing

1. Help the patient who is experiencing the intense emotion, memory, re-experiencing, or flashback to return to her Safe Place image and “Everyone can go back to your Safe Place image, know that you are here with Ida and Joan and all of your group, no one unsafe is here, you are surrounded by safe people, and no one from the past can hurt you.” This helps with reality orientation, as one would do individually to help a patient come out of a flashback experience. Add anything else you think will facilitate being in today’s reality with your specific group members.

2. Go into the experience in the role of Good Parent to stop whoever is threatening or hurting him/her. You can have the group members come into the image to stand around him/her protectively and you could say that they are providing witnesses and additional protection for the Vulnerable Child mode.

The latter option can act as a bridge into the second type of imagery work – working with an individual patient's image and bringing the group into the imagery. The therapists can emphasize that nothing can occur in the group that they cannot help with in some way. As a last resort, there could be a situation in which one therapist works with the individual patient and the other therapist responds to the needs of the rest of the group until a point is reached where all can resume the group's interaction.

*Step 4: Individual imagery change work that includes the group*

This is the most advanced imagery work. After imagery to connect with the Vulnerable Child mode, patients open their eyes and we briefly check what they are feeling. We then do further imagery work with a patient who volunteers. The basic instructions for the individual to group imagery exercise follow, along with a patient example.

**Steps of mode imagery change work starting with individual imagery**

1. We start in groups by having all patients use their Safe Place image.

We remind them before we start that they can always return to that image if they feel too frightened or overwhelmed during our imagery work. This instruction gives them practice actively modulating affect rather than letting Detached Protector take over.

2. After they have connected with their safe place image, we instruct them to switch to an image of their Vulnerable Child mode. We have them stay with that for a few minutes (longer later on in the group process).

3. Then we ask them to open their eyes and come back to being in the group.
4. We ask about their experiences. Usually there will be a group member who reacts more than the others emotionally. This usually means that there is a present situation that is linked to the Vulnerable Child image that they connected with.
5. If they are willing, we have that patient (P1) go back into the Vulnerable Child mode image, identify to the group where they are, how old they are, what they are feeling, and what they need.
6. The therapist who will start the imagery rewriting (T1) tells the group that she wants all of their little children to hear and take in what she is saying and know that it is for them too. This is an important therapist intervention to make the imagery experience more meaningful for all of the patients.
7. Based on the need of P1, the therapists and the group work creatively to supply the need or to help that patient get the need met.
8. T1 starts with connecting with P1. This can all be done in imagery, but we are comfortable doing it literally as well. This often means sitting closer, holding a hand, or putting a hand on their shoulder, etc. Therapists need to follow their comfort level and the customs of their culture.
9. T1 talks to P1 in a soothing voice about their need.
10. The other therapist (T2) must pull the group in, in one of a number of ways:

T2 can have the group move closer to P1 and T1.

If there is a naturally occurring opportunity for the group to enter the image with T2 or they can be called by name to join the image, to either help protect P1 or if it fits, to play with her.

T2 can ask the other patients if their little child ever experienced the feelings that P1 described.

If none of these works, T2 should not leave the rest of the group to go into the image without them rather T2 should stay connected with the group by connecting pinkies or eye contact, etc.

11. T1 goes as far as possible with the imagery to meet P1's need in some way. This may be limited, as it is in the example below, to

P1 feeling connected with T1. The priority is to connect them all in their Vulnerable Child mode in the imagery. Not more than 15 minutes should be spent on the imagery exercise for P1. If the rest of the group can be significantly involved, you may decide to let it go on longer. This is a therapist judgment.

T1 asks P1 to open his/her eyes and share what the experience was like. If P1 does not comment on the group's involvement, ask about what it was like to have the group involved in whatever manner they were.

T2 asks the rest of the patients about their experience.

12. Usually the content for your next imagery will come up from what one of the other patients shares.
13. Start over with the new example, repeating the steps. Switch which therapist leads.

### Patient example 1

Deb was a group member with frequent self-aggrandizing and passive-aggressive Maladaptive Coping mode behaviors that caused her to be disliked and at times to be a scapegoat in the group. For example, she was often not included in social invitations from the group.

Immediately after the group opened their eyes from the Safe Place image, Deb told us that she had been in Vulnerable Child mode all week because it was the anniversary of her best friend's death. She said this in a small voice that was slow and not her usual upbeat tone. She said that this was really difficult for her because she made her first suicide attempt just after this friend died. Deb volunteered the information that she had been doing some minor cutting during the week. Ida asked her to go back to the image of little Deb. She then asked the usual questions listed above in the instructions. Deb said that she was "8 or 9 years old and on the school playground, all alone, feeling lonely and weak". These answers were given very slowly with some difficulty. Ida asked if she could move to sit next to her and

Deb more quickly answered “Yes.” Ida asked if “little Debby” would like her to hold her hand. Deb said “Yes.” Ida said what a “precious little child” Debby is. In response to questions, Deb communicated feeling that “she mattered” and that she was “part of something” with Ida sitting by her. Ida said reassuring Good Parent things about “little Debby’s value.” Joan attempted to pull the group into the imagery by asking if Deb could be aware of “all of her little friends” here with her now who would be happy to play with her. Unfortunately, Deb nodded “No.” Because of her answer, Ida had her open her eyes and come back to the group and attempted a connection in the present by asking the rest of the group if their little children ever felt what Deb had expressed. Each of them shared some of their Vulnerable Child mode feelings and seemed to be connected on an emotional level. At that point, Joan asked the group if they felt comfortable taking hands as a “circle of little friends for each other.” They did so. We asked them to try to experience the “warmth, connection and belonging of the group” and to let that in. We then had them move to an awareness of their strong Healthy Adult women and the resources and support of that level of connection also. Patients responded to this nodding and smiling. After a few minutes the group disengaged hands. We ended that imagery work with a brief discussion of what the rest of the group felt during the imagery exercise and then moved on to do imagery work with another patient.

In the imagery example given here, we brought the patients’ Healthy Adult mode in as this was the beginning of the autonomy stage (3) for this group and they were ready to connect with that mode. After this session the group responded more positively to Deb. That evening they invited her to go with them for coffee. In subsequent sessions they were able to give Deb feedback about how off-putting her bragging was and how appealing she was when she was “more real” and let them know her, as she did in the imagery work. She was no longer treated like a scapegoat and her overcompensating mode behavior decreased.

Not every member in every session does specific individual imagery work, but all are involved in the group aspects of imagery as much as possible. We keep the individual focus relatively brief (not more than 7 minutes), using it as a launching pad of sorts for work that is targeted at common issues of

the group. In this way the group is always brought into any individual work. We avoid experiences that would feel like individual therapy while a group is just watching. A caveat is that we do keep track to balance in a general way the amount of individual focus each member has. Some may not want as much focus at a particular stage in their work and we are respectful of the individual pace of each patient with imagery work.

We ask patients to have eyes open or closed during different parts of the imagery work. Usually eyes are closed when the focus is on an image and open when the focus moves to the present and the group. Because eye contact is an important vehicle for emotional connection, whenever we focus on group input or connection we ask patients to look around and really take in what they are seeing. At the point when we begin individual imagery, the rest of the group usually has their eyes open. As the imagery work progresses, if it is a shared experience, we may have the group close their eyes and join the individual patient in the imagery. If it is a trauma experience we have them stay eyes open as there is no therapeutic value in their re-visiting that particular image. The example of Deb follows these general guidelines. Some of these issues are judgment calls for the therapist to make based upon the particular group of patients, but these are general guidelines.

Another way to look at these experiences for the other group members is in terms of vicarious learning. Their little children are present and observing. This use of vicarious learning can sometimes get around the Maladaptive Coping modes to the Vulnerable Child mode more effectively than a “frontal attack” would. We have observed very detached, avoidant patients at the edge of their chairs watching the imagery re-scripting of another, which they would not be willing, or possibly able, to do themselves. Their responses (e.g., tears) reveal that they have also been touched emotionally. The examples of Jane and Pat in the Detached Protector section of this chapter are examples of the therapeutic effects of vicarious learning.

*Brainstorming new endings for imagery rescripting of trauma experiences* Imagery work is used in group to identify “root” memories that occur when significant schemas are triggered, identify the needs that went unmet, and find ways to meet them now. An approach to this imagery change work, that is unique to group, is the brainstorming new endings for traumatic experiences, particularly abuse. This exercise is most easily described in an example.

### Patient example: Group Imagery Rescripting

Matt told us in group about the nightmares he had been having about his stepmother molesting him as a child. Joan asked if he would be willing to do some imagery rescripting work with that. He said he would, but he needed support as it was very scary to him (*good example of Matt asking for what he needed, which we validated*). Two of the group members he was closest to emotionally were sitting on each side of him; they asked if he would like them to move closer and he nodded yes. Another group member gave him the group Vulnerable Child mode fleece blanket and another gave him a pillow to hold. Two other patients moved to sit closer to Ida (*good example of them taking care of what they needed to feel safe, which was validated*). Joan checked to make sure everyone was in a safe enough place for us to begin (*important step for one of the therapists to take*). She then asked Matt to tell us his ideas about how we could rewrite the memory. He said that when he lived with his stepmother, he would get in the top bunk bed and roll into the farthest corner hoping she would not be able to reach him, but she always did. Sally (a patient) suggested that he make the bunk bed ten stories high so his stepmother could not possibly reach him and he could look down and laugh at her and make faces. Matt said that was okay, but he also always dreamt that somehow his mother (who was 3000 miles away) would know what was happening to him and would fly in and rescue him and take him back to her home. Joan asked if that was what he wanted to put in the new image. He said yes, that was what he wanted. The group decided they wanted to be in the image watching the rescue, but safe from the wicked stepmother. Everyone closed their eyes (except the therapists) and Joan described the scene and then a triumphant rescue with Matt's mother literally flying into the room, picking little Matt up, and flying out directly back to their home. Joan put herself into the rescue also and described knocking the step-mother over before she flew off to join little Matt and his mom. She described little Matt telling his mother how awful it had been and her telling him she was so sorry she ever had him visit his father, she thought he would be safe. She said that now that she knew she would never



have him go back and she would tell his father the terrible things that had happened, so he would understand why Matt left and be mad at or leave his horrible wife. The rest of the group then visited little Matt at home and Ida brought them all in ice cream sundaes to celebrate Matt being rescued and being brought home. Ida had everyone open their eyes and discuss what a good rescue it was, how they felt during it, etc. Matt reported great relief and was visibly less tense. Matt reported to the group over the next few weeks, that he had no more nightmares. He said that he practiced the rescue in imagery from his Safe Place image each night at bedtime and he reminded himself that he now had support, friends, and didn't feel so helpless.

This is an example of involving the group and both therapists in imagery change work for trauma. It is helpful to put in a fun element like the ice cream for balance. We get as creative as we can in these images as anything is possible in a child's imagination, and that is the level we are working at with the Vulnerable Child mode. The patients were acknowledged for what a good job they did supporting Matt. Matt's courage was validated. Some patients said they wanted the group to rewrite the "bad things" they had experienced too and the group went on to do that. Some patients had been able to put themselves in Matt's place and pretend they were being rescued.

Group schema therapists in training tell us that this type of imagery feels the most difficult to approach. Some issues are concerns about "getting right" the rewriting of the trauma in a group situation where you often have less detail about a patient's abuse experiences. Our suggestion is that you do brainstorming ahead of time so that you have the necessary information about what the child needed and needs. In addition, brainstorming allows the group to be included in a meaningful way. It also allows the rest of the group to know enough about what happened to evaluate what their safety needs are likely to be and to take care of them (e.g., the seating changes in the Matt example). We also point out that over the years we have made all kinds of "errors" in not perfectly rewriting trauma imagery and we have still accomplished good results. If we listen carefully, patients who are ready to do this work will tell us what they need in it.

### Patient example: Rescripting “do-over”

An example of a patient who was able to tell us what she needed as the imagery developed was Karen, who wanted to rewrite her experience of being left with an uncle as a babysitter who sexually abused her. She told us that it took place in the bathroom when he would make her take a bath. After the group had done some brainstorming, we thought that we had enough information to proceed. When we got to the point of Ida going into the bathroom to protect her, it was clear that something was wrong with that suggestion. As we could think of a number of possible problems, we had Karen come out of the image to talk about it some more. We discovered that she did not want Ida to be “exposed to my awful uncle.” Initially we reassured her that we were strong enough to handle him, etc. This did not allay her concern for us, so we changed the script again. We all went back into the image and intervened at an earlier point when she was still at home and had not been dropped off at his house. The group came along as reinforcements and to ask little Karen to come out and play with them instead of going to the uncle’s house. They also decided to throw eggs at the uncle’s car. Everyone felt safe enough with the Good Parent therapists there to do that. We did not stop them. The eight “little kids” also decided that a campaign should be started to run the uncle out of the neighborhood so that Karen never had to see him again. Karen liked this version. The fact that we stopped and started the imagery had no negative effects. It made Karen feel good that she was listened to and the group was able to get very involved in the second imagery. Patients tell us that the fact that we will let them have so much control of the imagery allows them to be brave enough to try it and has added healing effects for their Vulnerable Child mode.

The progression in Vulnerable Child mode imagery represents the psychotherapeutic equivalent of missed childhood emotional development, undertaken to accomplish secure attachment with the therapists. Through this process therapists are internalized as Good Parent figures. This can be a transition first to a Good Parent in the patient, and ultimately to the patient’s Healthy Adult mode, which develops through this process. It has been our experience that imagery work has large effects on patients fairly quickly.

*Corrective emotional experiences from belonging to a group as a supportive family* Another way that schema mode change occurs is the process of experiential “antidotes.” Many mode healing experiences for the Vulnerable Child mode take place in response to emotional validation, acceptance, kind treatment, and respect in the group. These experiences create feelings of being worthy that contradict early maladaptive schemas that developed from core needs for validation and acceptance not being met in childhood.

### A group experiential antidote

An example of an experiential antidote was Ann’s experience of group forgiveness for being 5 minutes late due to an accident on the road. Ann had been harshly punished for any imperfection as a child, and no explanation was ever enough to prevent blame and harsh punishment from her mother. She consequently internalized a harsh Punitive Parent mode that punished her with self-injury whenever she made a “mistake” and developed a Detached Protector mode that avoided any interaction with people in which a “fault” might be exposed. The day she was late, she had to force herself to come to group, fearing the worst. She came because if she had not she would have broken a group ground rule. Whether she decided to come in late or go home, she was sure that she was in big trouble. She was shocked when she arrived at the session and all the group did was express concern about her and relief that she was unharmed since she never came late. The group had no idea, until this experience was discussed, that they were providing experiential evidence that she did not have to be perfect to be accepted and cared about. This was a breakthrough in awareness for Ann, who realized that her lifelong avoidance of relationships as a way to protect herself was not necessary in her adult life. Many opportunities for these emotional level “antidotes” and consequent mode change occur in GST where affect is aroused and cognitive processing is facilitated by therapists and other group members.

*Corrective emotional experiences from group siblings* The sibling aspect of the group as family adds to both the complexity and the opportunities of GST. For some patients, experiential work feels safer in the group because of the presence of “siblings.” Sometimes therapists are scarier because of

the Vulnerable Child mode of patients perceiving us as parent figures who might be punitive or demanding. When this happens, imagery work may feel too frightening to risk in the Vulnerable Child mode. If siblings played protective roles historically for a patient, they can act as an additional support as healthy “big brothers or big sisters.” Of course, the opposite can be true, if siblings were abusers. In that case imagery work would need to include protection from the biological siblings and the role of group members in imagery would need to be approached carefully with attention to gender. A positive group experience of being safe and protected can be desensitizing and schema challenging (e.g., mistrust/abuse) when abuse occurred with biological siblings. We have also had the experience of a traumatic memory we were not cognizant of emerging in a group session triggered by a sibling. As long as the therapist is able to flexibly move with whatever role-play or imagery rewriting the situation requires, surprises like these coming from the added emotion-evoking potential of groups can be therapeutic opportunities.

In groups, sibling rivalry issues arise naturally and the resulting emotions and schema triggering that occurs can be explored and used as added opportunities for corrective emotional experiences. These can be important therapy moments for the patients whose Vulnerable Child mode always felt left out of the parents’ attention or that their siblings were favored, as they can experience attention and fairness from the therapists. Another possibility is that a patient will not feel that they are getting what they judge to be their fair share of attention, or they feel overlooked in some way, but they speak up about it and their need is met. Experiencing that you can ask for attention, and receive it without being shamed or having to demonstrate your need by desperate action (like a suicide attempt or threat) is important emotional learning for patients with emotional deprivation schemas. The therapists’ ability to balance their responses to individual members is particularly important in BPD groups as is the division of time spent focusing on each patient individually. Therapists cannot be expected to be perfect, but if a complaint about lack of attention is made it is important to take it seriously, assert that you do not want to do that, find out what you are doing that gives that impression, apologize, and try to balance the situation. We will respond differently to different patients despite our efforts to be fair, based upon our own schema profile. Being willing to look at our behavior when asked to is a critical therapist skill in ST. We want to give patients the healing experience in the group family that there is “enough for everyone to get something,” unlike many family-of-origin experiences. To ensure that this

is what patients experience, we make statements such as, “We may not get to everyone today, so we will be sure to start next time with the folks we didn’t hear from today.” Such acknowledgment can prevent feelings of being treated unfairly and acknowledge their right to have the healthy need for attention met. We try to anticipate not having enough time to hear from everyone and take preventative action. We sometimes ask the group when there is about 15 minutes left, “I see the time is getting short – who wants to make sure to be heard today and who is okay waiting for next session.” Asking that question over time gives patients opportunities to practice speaking up to get their needs met. If a situation occurs where they do not speak up and later report hurt or angry feelings over not being given time, we acknowledge being sorry about that and look at what mode interfered with speaking up. Almost anything that happens in the group has some potential for “opportunity work” if we pay attention to the group’s process (see ACM 3 for Angry Child mode discussion topics).

*Transitional objects and limited reparenting*    The use of transitional objects is consistent with the developmental approach of ST and can be an important component of limited reparenting for the Vulnerable Child mode. We give patients small pieces of fleece or silk, smooth stones, a small souvenir from a vacation (e.g., Joan likes to pick up smooth shell pieces on the beach and brings one back for each patient). We ask patients about their use of objects such as comfort blankets as a child. They usually had something at one time, but also a story of their parent throwing it out or making fun of them about it and feeling devastated. When this has happened in childhood, patients sometimes try to protect themselves by not attaching to anything again. These are the patients who at first refuse any comfort items or transitional objects. We explain that just as they are developing and being able to access a Good Parent figure in themselves, transitional objects from the therapists and group can remind them of comfort that they have experienced in imagery exercises or just being in group sessions. We do not force patients to accept transitional objects, but may ask them to give it a try just to see what happens. We sometimes offer to hang onto it for them in case they want it later. Other objects are provided depending on what appeals to patients individually, such as written cards, rocks, scent bags of lavender, and little and big stuffed animals. We suggest that they experiment with a variety of objects and take the time to use them for recalling soothing and connection.

### Patient examples: A shared transitional object

Groups sometimes make a collective representation or “group transitional object.” One of our groups constructed a collective “soothing blanket.” They voted on what it would look like – they chose pink fleece cut in the shape of a heart large enough to wrap around one’s body. They had the group artist write on the center in calligraphy “We love you.” and then each of them wrote a message to the Vulnerable Child mode on the blanket. The blanket is always in the group room and it can be requested by a group member or offered to one who someone else thinks could use the comfort.

One of our patients, who was inspired by the exercise, also made a literal representation of her new Good Parent consisting of the therapists and supportive peers. She cut out a one-dimensional parent figure made mostly of paper and cloth that she could literally wrap around her body as if she was a small child being wrapped in a hug. This was done by a patient who experienced severe childhood sexual abuse and who had difficulty with anyone actually hugging her.

### Therapist script: Transitional Objects

Very young children must develop the cognitive ability to know that a parent exists even if they cannot see them. Until they develop “object constancy” they have intense separation anxiety. The next step in healthy development is to be able to evoke the soothing image of a parent when they are gone. This is how the ability to self-soothe is developed. Children often have their blankets as transitional objects that remind them of the soothing from the parent, for example, being tucked into bed with a soft warm blanket. Having a tangible object that represents the parent helps them feel that the parent is real. We have discussed how the abandonment fears of patients with BPD go back to the childhood experience of no reliable, predictable caregiver to take care of needs for protection, comfort, love, etc. We are working in imagery to supply those experiences to your Vulnerable Child mode. It makes sense that we would also want to make use of

transitional objects for your Vulnerable Child mode. These objects can help your Vulnerable Child mode make the transition from comfort and soothing coming from the outside to being able to know what to provide from the inside – from your Healthy Adult. So over the course of the group we will develop together various representations of the group and the therapists for your little children to use for comfort and reassurance. This is another way that we can help you correct things that you missed as a child. We will also make a Vulnerable Child mode soothing box or treasure chest for you to keep your transitional objects in. We can decorate large shoe boxes together as a fun activity for our Happy Child mode and Vulnerable Child mode together (see VCM 3 for a therapist script regarding transitional objects).

*Behavioral pattern breaking* Behavioral pattern breaking work with the Vulnerable Child mode consists of putting into practice the patients' awareness of needs and how to meet them, first in the group and next in the world. This work bridges to the Healthy Adult mode work, as it is the patient's Healthy Adult who takes the needed action. The group can also be a place to develop a sense of competence in their ability to act effectively to help others. Many of our patients tell us that being a mentor in the group was the first time that they ever felt either competent or valuable. As social isolation and alienation lessen through group experiences, patients begin to have interactions with safe people outside the group. They feel able to protect the Vulnerable Child part of them with less use of Detached Protector or other Avoidance Coping. For behavioral pattern breaking work for the Vulnerable Child, we use the Steps in Mode Management form to pull together the information collected and to record the plan for change. BEH 3-1 is a patient example of this Mode Management Plan and AW 2-2 is the corresponding Mode Awareness Monitoring form. The Mode Management Plan asks the patient to answer three questions: "How can you use your awareness? How can the group help? How can the therapists help?" Of course, the answers must be realistic in terms of what others can and are willing to do. It is useful to have recorded answers to these questions that you can refer to at times when patients feel overwhelmed and hopeless and do not think anything would help.

We integrate and summarize the work done with the Vulnerable Child mode in an Antidote Summary form (BEH ANT-2).

### *The Happy Child mode*

The goal of ST for the Happy Child mode is to develop and strengthen it as one of the two healthy modes identified in schema theory. Much has been written about the importance of play and how it contributes to a child's development (Lockwood & Shaw, 2011). Many skills that are vital to healthy emotional development are acquired through play: we develop our creativity; we learn to be spontaneous, to negotiate with others, and to communicate our wants and needs. These are important life skills that patients with BPD often miss. Play has usually not been much present in their family environments.

In psychotherapy, play is a powerful tool that helps abused and emotionally deprived patients break through the blocks of mistrust and fear by providing safe experiences where they can feel and learn to trust. Accessing the joy of the Happy Child mode can shatter the belief that they are "all bad." Play is an enjoyable experience for both the therapist and the patient because it is a safe way to attend the needs of the Vulnerable Child, the Angry Child, and the Happy Child. The experience of play can be a reprieve from the prison of the Punitive Parent mode.

*Cognitive interventions* The focus for the Happy Child mode is on emotional development, which although parallel to cognitive development, is relatively independent. Cognitive interventions are not particularly used here.

*Experiential interventions* Elements of play are easily introduced in the group setting. As the group bonds and forms the multiple overlapping attachments of a working psychotherapy group, the supportive atmosphere that is generated provides a comfortable mutuality that lends itself to play. In general, we use humor and a playful approach to GST work. It is a way to connect with patients that is independent of our formal roles, which fosters genuine human connections between therapists and patients. Given the number of triggering schemas they have related to their performance and evaluation, playfulness can become a welcome exchange that does not involve judgment. In imagery work, we create images of play, fun, and joy and have patients practice accessing those along with the Safe Place images.

We have observed that patients with a temperament predisposed to BPD can experience the positive with the same intensity that they do the negative. We share this observation with them to motivate them getting through the



pain of the Vulnerable Child mode. It is important that we help them learn to balance their frequent negative or painful experiences with opportunities in the group for intense positive experiences with play. Using play in the group provides us with evidence to remind them that they can experience joy. Play and sharing joy are additional connections that add to cohesiveness for the group. We also foster play for its role in exploring likes and dislikes, which provides information that is an early part of identity formation. Play can be a medium for building confidence and learning about and incorporating reasonable limits. What follows are some examples of play developed with our groups. The possibilities are endless, limited only by the imaginations of you and your group.

- **The Face Game** Each group member is given a balloon to blow up and soft felt pens. They are instructed to draw a face on the balloon showing how they feel. Before they identify their feeling, the group tries to guess. This can be a safe way to begin talking about feelings, why we have them, and how we can meet the needs underneath them. Of course, after drawing the faces, it can also be fun to bat the balloons back and forth at each other.
- **A Safe House Project** One of our patients told us about using an image of a “safe house” filled with love as a Safe Place image for her “little child.” This idea appealed to the rest of the group. They said, “We could all build one in our imagination, and then share how we decorate it.” Someone in the group interjected, “Why don’t we build a doll house together and call it our safe house.” This suggestion was met with enthusiasm, so the Good Parent therapists found a house for them to build together. This turned into a wonderful learning experience for everyone. The patients learned that they could use tools, follow a blue print, deal with design issues, and learn to negotiate design choices, work within a budget, and divide tasks. They negotiated who would decorate each room and learned to work together. In the course of the project they shared laughter, joy, and a sense of pride and mastery with their contribution to the building of the safe house. The house was an important anchor for the Safe Place imagery of that group.
- **The Winter Olympics** refers to a particularly imaginative play experience for the Happy Child mode that occurred in the inpatient BPD program. Patients had been complaining about nothing being on TV except the Winter Olympics. Hearing this, Ida saw an opportunity for fun that could involve the group. She described to them with great

enthusiasm the many possibilities with game choice, costumes to represent various countries, refreshments, etc. As usual, her Happy Child was infectious. Planning for the event occupied the patients for a few days. Highlights included a plate of spaghetti hat for Italy and a Moose hat for Canada. Teams were formed with athlete participants and cheering fans. An opening ceremony was held to the enjoyment of all. The games emphasized fun over skill, like the “speed-skating” down the hallways with boxes as skates. The group referred to this shared experience many times, always with big grins and twinkling eyes. Sharing this kind of fun builds cohesiveness and provides a positive memory of an experience shared with peers and therapists. The modeling by therapists of having fun and even being silly is supportive for the Happy Child modes of patients who had not experienced adults in this way in childhood. The experience was challenging to restrictive modes such as the Demanding and Punitive Parents.

- **Keepsakes, Memories and Connection Boxes** Our groups regularly make Vulnerable Child boxes that the patients use for comfort items and the treasures of their little child. We decorate shoe boxes creatively with a variety of inexpensive papers, stickers, buttons, ribbons, etc. We encourage patients to collect things to remind them that the needs and attachments of their little child matter and must be recognized. Their collections consisted of small smooth stones or shell pieces from their therapists’ trip to the beach, crayons, bubble gum, pictures, bags of scent, cards, etc. Therapists and patients write positive affirmations on cards. Patients make things for each other, such as tapes of relaxing music and book marks, all of which serve as transitional objects. The box is a resource they can take out for soothing and to look at the treasures, eat the candy, blow bubbles, etc. Patients report that having this resource aids them in learning about comforting their little child. From their Healthy Adult mode they can comfort the “little child part” by reading a card from the box, telling him/her about the objects in the box and why they are special as you would do to a little child, play the tapes, etc. We emphasize to patients that it is not possible to re-do your childhood, but it is possible to respond as an adult to the unmet needs of the Vulnerable Child mode. We talk about the losses of the Vulnerable Child as well, and the group can support both grieving losses and taking healing action for the Vulnerable Child today with play and comfort boxes. Some patients struggle with the treasure box exercise because it activates their Punitive Parent mode. We acknowledge this and as the Good Parents, offer to

keep the box safe for them until they have diminished the power of the interfering mode.

In all of these play activities we are sensitive to introversion–extroversion differences with patients and make sure that all are included and validated. We identify the need for and use of play when it occurs in imagery (e.g., sitting on the playground at recess wanting to join in, but fearful of rejection). As in the example of Deb, scenes of being alone on the playground occur frequently when patients connect with their Vulnerable Child mode. Having a little friend from the group join the child to play in imagery can be very healing and give the whole group comforting play images to recall. Short play activities can be interjected into the group session like clapping rhythm games, and all joining hands and moving and/or singing together. The group can regularly plan fun activities to share like creating a group mandala or a picture representing them all as a shared symbol of safety and unity. Birthdays and other special events can be celebrated by the group family. For many patients these celebrations will be the first they have experienced without the attachment of a negative experience. Therapists find and express verbally and non-verbally, what is delightful and special about each group member's Happy Child. The group discusses feelings and reactions to our play together, including grieving for the lost play and joy of their childhood. We plan ways of protecting and holding onto the Happy Child now that he/she has been "found." We watch for the intrusion of the Punitive or Demanding Parent modes. One of our groups made a "No Punitive Parent Modes Allowed" sign for the group room door. We end groups in which play is used in the usual manner with the Safe Place image, sometimes adding Good Parent messages to bar any retribution from the Punitive Parent mode.

### *The Angry Child mode*

#### Goals of schema therapy work with the Angry Child

Teach the Angry Child appropriate ways to express emotions and needs. This requires the following:

- Learn the difference between feeling angry and acting impulsively, and the more basic distinction between feeling and acting

- Recognize “all or none” thinking to prevent overreacting to minor slights or delays
- Use reality checks to form realistic expectations
- Develop Schema Mode Flash cards to maintain self-control that you can use in “time-outs” or read before taking any action
- Be able to act assertively to express your needs and make requests within the limits of the situation
- Learn healthy ways to express anger as a Healthy Adult

*Understanding the Angry Child's needs* The Angry Child mode reflects the innate response of a child to a need not being met. In this mode a person needs to be allowed to vent and be heard within reasonable limits. The therapist behaviors needed to manage this mode in a group were discussed in Chapter 4. In this chapter we discuss the adaptations needed in ST interventions for the Angry Child mode for use in a group. It is important that we make it clear to patients that we are not afraid of their anger and that we will set the limits on becoming abusive that they may not be able to. This is reassuring for patients who fear their own anger as they have only seen anger be abusive and out of control with people being physically hurt. It is also reassuring for patients who are terrified of others expression of anger because of experiencing abuse or others being abused in their families. We gave the example in Chapter 4 of a patient saying “We dealt with a conflict and no one was killed!” Therapists must have worked through any schema issues they have with the expression of anger so they are able to support and encourage patients in the Angry Child mode venting completely. This requires seeing Angry Child outbursts for the “temper tantrums” that they are, which is sometimes challenging when one comes from a large man. The Angry Child mode is one that can hook therapists’ schemas related to anger and its expression or even one of the therapists’ parent modes. Recall the example in Chapter 4 where a patient mentor’s angry expression clashed with Joan’s Demanding Parent expectations for her behavior. This is something to be alert for and a time when having a second therapist for back-up is very helpful. The intensity of anger in patients who have been abused and whose anger has been suppressed can be very strong (ACM 1 is an information handout for Angry Child mode).

*Cognitive interventions* Schema mode flashcards are a primary cognitive intervention for the Angry Child mode. They are developed in part with the group and the group is an obvious place to practice using them.

### Mode flashcards (form ACM 2)

You can learn to reduce and channel the Angry Child mode by accessing your Healthy Adult mode to express your needs in a way that others will hear and be better able to respond to or negotiate with you. Schema flashcards remind you to stop the action and think.

- Reality Check Flashcard – Think – Example: I need to remember that I don't get what I need when I have a tantrum. I need to keep my long-range goal in mind, don't blow it by blowing up.
- Deal With Feelings Flashcard – My “Cooling Out” Technique – Example: When I feel my arm muscles and jaw tensing, I will take three deep breaths and, if I need to, take a short break. I can always make an excuse to get away for a minute or two to calm down and engage my Healthy Adult mode.

Cognitive interventions for the Angry Child mode include work with cognitive distortions related to the mode. At first patients will be looking at these distortions after Angry Child mode outbursts and later in a preventative way. Circle monitoring is helpful in identifying the early warning signs and in sorting out “wants” that are related to pleasure from “needs” that are necessary. Additional monitoring identifies thoughts that “fuel me up” and “thoughts that cool me down.” We help patients identify their personal early warning signs of the Angry Child mode. We also educate them about the adaptive value of anger. Anger at its core is a reaction to needs not being met. Like all emotions, anger gives us important information about our experience. Patients do not routinely have access to this information, which adds to instability of identity. Disconnection from their anger creates the more global disconnection from emotion that is related to the BPD experience of emptiness (Homework example ACM 4).

Patients tend to label all of their anger “Angry Child mode”. In part, this is due to not learning that anger can be healthy and productive. Healthy

adults, for example, get angry, but their manner of expressing anger does not violate others rights. Being able to express anger with reasonable limits is a critical skill people need to be able to maintain interpersonal relationships. We do some assertiveness practice in group to help them with Healthy Adult anger expression. Given the overall amount of treatment they receive, BPD patients have usually sat through more than one assertiveness training class, so they have skills to pull from. The issue again is that until the schemas related to worth and fears of loss of control are dealt with and the Dysfunctional Parent modes limited, patients with BPD are not likely to use the assertiveness skills they have been taught effectively. Approaches like Dialectical Behavior Therapy are very good at teaching skills, but do not address the underlying schema barriers to patients actually making use of these skills.

*Experiential interventions* The group must be a safe place for the Angry Child to vent anger. Role-play work is particularly useful here as there are numerous potential “actors” to call upon. To help vent the underlying rage of the child whose needs were not met, we use an effigy to represent the target of the Angry Child’s anger. This may be someone from the past (e.g., parent, coach, teacher, or bully from school). The patient’s awareness might be that the target is contemporary, but by definition if the Angry Child mode is involved a root has been touched. The Good Parent role that group schema therapists take is nonetheless a “parent” role, so it is likely that one of us will be the contemporary object of the Angry Child’s anger at some point in therapy. If it is one of the therapists, ideally the venting is something the therapist can hear within limits. If it is another group member, the venting or alternative anger release work is directed in a different way and then the interpersonal issue is dealt with (if one is still present). It is important not to have Angry Child venting directed at a patient in Vulnerable Child mode. Doing Angry Child mode role-plays requires making sure all of the group feels relatively safe or measures can be taken to accomplish that (e.g., patients are behind the therapists or behind a wall of pillows).

### Therapist tip: Comfort with anger work

In many cultures, it is not uncommon for therapists to have grown up in households in which there was not a lot of overt expression

of anger. When this is a therapist's experience, they may need to do some self-therapy work to have an adequate comfort level for working experientially with BPD patients' venting in Angry Child mode and other intense anger expressions. Joan grew up in a family where people were not allowed to raise their voices without gaining the wrath of her mother. Even her big, strong policeman father was subject to this rule. As a therapist working with a group of combat veterans, Joan realized that she became startled in response to expressions of intense anger. She joined an experiential self-therapy training group for therapists to do the needed work to be able to stay present for patients. Some of what she learned there was how reassuring it could be to get in the corner with other group members and cover yourself with big pillows when a big, tall, loud man was pounding a mattress with a tennis racket and yelling. She got to the point where she could be the person hitting the mattress and even be the therapist standing in front of the mattress as someone else was hitting and yelling, letting the waves of emotion wash over her. She shares this story with patients, as applicable, when her group does Angry Child work. We need to be able to say to patients that their strong emotions are not too much for us, that we welcome them.

The collective physical strength and emotional presence of the group can provide feelings of containment that are reassuring to other patients and to the therapists when experiential anger work is done. You can always de-escalate the intensity of any emotion, simply by stopping the action and suggesting, "Everyone take a deep breath and let's do a quick check in to make sure we all feel safe before continuing." This does not have to communicate to the patients that are venting that they have to stop; rather it gives others the opportunity to move or do what they need to, to protect themselves. The message is that we will find a way for everyone in the group to get what they need, even when those things are different. This message is a central, important one to give to our patients. The actions by therapists to ensure safety provide one of the experiences for the Vulnerable Child and the other child modes of healing from limited reparenting, and the experience of having needs met in the group family.

### Patient example: Anger expression in group

Jim, a very large, strong man, had a lot of rage about his early parental abandonment and his childhood rejections and abuse. He was easily triggered by his abandonment schema into the Angry Child mode and then protectively into Angry Protector mode, making it very difficult for anyone to connect with him. Jim's abandonment sensitivity was so intense that when it was triggered he moved with lightning speed from Vulnerable Child mode to Angry Child mode to Angry Protector mode to Bully-Attack mode. This flipping of modes could occur whenever the group focus moved away from him. He visibly began to look angry and agitated, then would angrily tell us that he was "being abandoned by the group, just as my parents dumped me as an infant." This sometimes moved to him yelling and calling the group a "bunch of bitches" as he stormed out of the group slamming the door so that it shook the room. By the time one of the therapists went out to check on him, he would have flipped to Punitive Parent mode and be beating himself up for his behavior and declaring how bad he was. Jim was eventually able to understand the intensity of his reaction in schema terms, **vent his rage and pain at his parents in role-play instead of at the group**, and see the other group members accurately as the accepting caring people they were, who he could safely let in and connect with. This example also illustrates how effectively mode reactions triggered in group interactions observed by the therapist can provide material for mode change, in contrast to less salient patient descriptions in individual therapy outside of session events. Joan never saw these reactions in sessions as Jim's individual therapist, as obviously her attention was always on him in that modality.

Group experiential exercises can be used to access the Angry Child mode of more repressed patients. Two examples are: "tug of war" games, and contests in which back-to-back patients try to push each other across the room.

*Playing with anger* Anger is very frightening for many BPD patients. They associate trauma, abuse, pain, and fear with the mere mention of anger. Asking them to engage in play to deal with anger is met with great hesitancy, fear, and skepticism. However, games like tug of war, and stomping and popping



balloons are a safe and effective way to release anger. Patients begin to realize that movement and play are good tools for releasing anger, and it feels much better than shoving it down and numbing out. A sound game such as making the best cow sound or the loudest pig noise is safe and fun. It can be the beginning step for the patients to claim their voice. Being able to say “Stop” and “No” when they are feeling anger can be taught through the use of play. Patients over time discover that nothing bad happens when they get angry and that they can control expressing the feeling and control the action.

### Therapist script for anger exercises

Ida presents this work by asking the group, “How many of you have ever had fun with anger?” No one ever says, “I have.” She proceeds to demonstrate how that is possible. She gets a large towel out of the Therapist Tool Kit and asks who thinks they can pull her out of her chair. Someone usually thinks they can and if no one volunteers, she will choose someone and at last resort use Joan. She then asks half of the group to cheer for her and half for the other person. This pulls the group in and adds the fun element. It is difficult to pull Ida out, so there is always a good deal of play, grunting, and groaning through the exercise. Having the patients cheer keeps them active and focused on the demonstration. It is easy for her to point out when it is over how the muscles used to release anger in the tug of war game are the same ones we use when we hold anger in or are used in physical aggression. Typically at the end of the exercise, the volunteer feels more grounded and, if they began the exercise angry, less angry. The group then pairs up to try the exercise. BPD patients are typically so afraid of anger that they only experience it when it has built up to volcanic proportion. At those times, the Impulsive Child mode is likely to kick in, and they lose control in extreme action, that frequently has negative interpersonal, work, and even legal repercussions. They may also take it out on themselves with self-injury, either from the Impulsive Child mode or in a flip to Punitive Parent after some action they are ashamed of. So exercises like this are very important for them – to be able to access the Angry Child mode in a safe manner in which play breaks through their fear and “nothing bad happens.”

In setting up these exercises it is important to structure in limits like “both people must stay in their chairs and when one is lifted off the seat, the exercise is over.” A line could be placed on the floor for a tug of war involving more people. With therapists monitoring, these are safe exercises to access anger in a setting where it can be worked with.

### Therapist Tip: Distinguish which angry modes

It is important to distinguish the Angry Child mode which is a normal, instinctual expression of anger when needs are not met from the maladaptive Coping modes like Angry Detached Protector or Bully-Attack. For the Angry Child, venting is therapeutic and meets their need to be heard. For the Angry Detached Protector, venting only serves to create distance and what is needed and therapeutic is empathic confrontation. With the Bully-Attack mode, venting will be directed aggressively at someone, and the therapist’s limited reparenting response in that case will be limit setting. It is also important within the Child modes to distinguish the Angry Child mode and Impulsive Child mode, as they need different things in limited reparenting. It is important to separate the emotion of the Angry Child mode from the action of the Impulsive Child mode. As Good Parents we want to communicate our acceptance of the child and his/her feelings, but set limits on behavior. There is further discussion of therapist intervention by mode in Chapter 4.

As “parents” to a large family, we must consider all of the “children.” It is important to clarify the boundaries for expression of anger in the group so that everyone will be safe and no one is hurt. Safety needs to be available for the other group members when anger is being expressed. Depending upon your group and the size of your group room, venting may need to take place with one of the therapists in a separate room. Either identify for the group, before or after, what the anger is about to prevent fears that it is personal. Of course, it may reflect a conflict between members and, if so, needs some mediation and resolution in the group. Sometimes this is not possible and the mediation may occur with the therapists and then be reported to the group. Empathic confrontation may need to take place privately, since individuals can feel exposed and vulnerable in the group. At

other times, if a disruptive behavior has occurred repeatedly in the group, empathic confrontation needs to take place there. We find it helpful to “set the stage” before beginning an empathic confrontation, then allow space for other members to get involved as long as it remains empathic and constructive. A therapist would need to intervene if what starts as empathic confrontation turns into “ganging up on” a patient. The group can give a member feedback about how they are affected by an Angry Child tantrum in group. Therapists can use selective self-disclosure to give also feedback about the effects on them. Therapist feedback may take the form of “We love you, but feel hurt and angry about these repeated verbal attacks.” A brief discussion of intent and effect and actor–observer differences in attribution can be useful groundwork to provide for giving such feedback. In working in group with personality disorder patients, it is important at the cognitive level for them to understand the difference between intent and effect, and that they are still responsible for the action they take. We coach the practice of more constructive, modulated expressions of anger, for example milder expressions of anger for small irritants.

### Anger questions for group discussion

- How does the Angry Child cause problems for you?
- How is the Angry Child helpful to you?
- Is it possible for you to express anger in a Healthy Adult way? How do you do that?
- Write about a time you expressed anger in a way you felt good about.
- Do the same for a time that you felt bad about.
- What did you learn about anger growing up in your family?
- How was anger expressed and who was allowed to express it? Everyone, or just dad, or mom, or both.
- Did anyone in childhood teach you how to handle anger, or express it in a healthy way?

*Behavioral pattern breaking interventions* The group is an excellent place for Angry Child mode to be triggered, accompanied by therapist and other patient feedback supporting flashcard use for the control of action and

assertiveness in expression. Much of the behavioral pattern breaking comes in work on the Healthy Adult mode.

## **Dysfunctional Parent Modes**

### *The Punitive Parent mode*

Eliminating Dysfunctional Parent modes is a ST goal that can be significantly augmented by the participation of a supportive group. An entire group of strong adult patients can more powerfully challenge and banish the Punitive Parent mode than a patient (who feels like a small helpless child) and his/her individual therapist are able to.

*Awareness and cognitive interventions for the Punitive Parent mode* Much of the awareness work with the Parent modes is cognitive, so we are combining our discussion. As we do with the other modes, this work begins with education and monitoring. We refer to the education about childhood development, normal needs, and what healthy parenting is that we introduced early in the group. After identifying that all patients have an internalized Punitive Parent mode, we discuss who the tone of voice sounds like – a parent or other significant person. We ask when the voice started. It is important to explain that the Punitive Parent mode is the internalization of only the punitive aspect of parent/caretakers, and that it is determined at least in part by the parents' own schema issues and how their childhood needs were met (PPM 1: Information handout on Punitive Parent mode; PPM 4: Dysfunctional Parent messages worksheet). It is important to discuss any reactions patients may have to using the term "parent" for this mode. Family loyalty or childlike fear of punishment for "telling secrets" may impinge more in the group setting than in individual ST. Finding an acceptable individual label for this mode is often more important than for the others. One patient may name the mode "mean mommy" and another can react very negatively to that label. This can be another group opportunity to point out that there is no right or wrong about this, rather that people have had different experiences. We also make it clear that the Punitive Parent mode or Demanding Parent mode are often made up of the internalized negative messages of parents combined with other caregivers, teachers, coaches, etc. – that we are not saying that *all* parents are *only* bad.

Often in BPD groups, all patients suffered extreme abuse of some kind and defense of parents is not so much a group issue to address. We do say directly that when abuse occurs – whether emotional, physical, or sexual – the adult perpetrator is “bad.” It is important to say out loud a number of times that children are not responsible for abuse, and that they were not abused because they were bad even though their abusers may have told them that. Internal conflict around these issues will not be settled in a few sessions, as the hold of the Punitive Parent on patients with BPD is very strong. It can be strongest for the most abused patients as despite their adult chronological status their “little child” is terrified of what a parent can do. We present information about the effects of punishment on children, the damage to sense of self, shame, and the self-hatred this engenders, as patients sometimes echo the words of their Punitive Parent by saying, “If I wasn’t punished, I would not have learned right from wrong.”

We discuss the Punitive Parent mode as “not” the patient, but something that we took in growing up which has no positive use that we need to get rid of. Many BPD patients experience the negative parent modes as voices that are inside or even outside of them. The latter is one of the reasons that some BPD patients are misdiagnosed as schizoaffective. As with the other modes, we have patients monitor what triggers the Punitive Parent mode and what role this mode plays in their self-injury or suicidality. We help patients in group assess the effects of the Punitive Parent mode and Demanding Parent mode using the questions from the Young Parenting Inventory. We discuss their awareness of the Dysfunctional Parent modes in them. The “Mode Awareness Monitor” AW 2-4 provides an example of the information we ask patients to collect about the Punitive Parent mode.

Cognitive restructuring, flashcard use, pro and con lists, and self-talk are the main cognitive interventions we use with the Punitive Parent. Patients identify the role of self-talk that maintains Punitive Parent, how to “catch it,” and how to change it. The group can be very helpful in pointing out examples of this mode being present in other patients’ speech and can be helpful in challenging it. The group can participate in the reattribution of “badness” from the innocent “little child” to bad parenting. We also use a pro and con list to evaluate change in the Punitive Parent mode. PPM 2 is an example from one of our patient groups and PPM 3 is a blank form.

As with other maladaptive modes, cognitive distortions play a significant role in maintaining the Punitive Parent. We focus on the main distortions related to this mode in exercises and homework.

### Cognitive distortions maintain unhealthy parent modes

Be aware of and record any time that you notice ALL or NONE thinking during the week. Record your version of this distortion, then list what you know to be the FACTS that dispute the distortion. Also record the effect that looking at FACTS had on how you felt and what you did.

- Distortion:

Effect on how you felt

Effect on the action you took

- Facts:

Effect of Facts on how you felt

Effect of Facts on what action you took

Were you more affected by Facts or the Distortion?

*Experiential interventions* We use an exercise in groups where we construct a cloth figure to represent the Punitive Parent mode. Using a tangible representation serves a number of therapeutic purposes. It demonstrates the theory of ST that this is an internalized negative object, not the patient. The first step in eliminating the Punitive Parent mode is the patient understanding that it is not their voice. Patients draw a face on the effigy, which usually looks like a monster or demon. This characterization is useful as it does not even look human, underlining the point that the Punitive Parent mode is the selective internalization of only the negative aspects of caregivers, not the whole person. This is helpful for two reasons: patients don't think that they have to separate completely from their actual parents and from any good present in those relationships, so abandonment fears are not stirred up, and we do not run into family loyalty issues as much (i.e. the idea that they are disloyal to the parent for telling secrets that lead to others having a bad opinion of the caregiver). The Punitive Parent mode effigy evokes a lot of emotion, beginning at times with fear, but moving on to anger and rejection.

We first use the effigy as a site for patients to write the negative messages from the Punitive Parent mode on. This process is another concrete action to get the message out of the patient. We have them think about getting rid of the message by leaving it on the effigy. In the Safe Place image ending of groups when doing Punitive Parent mode work, we remind them that they are leaving those messages here. We suggest during the imagery that if they think of another message, they can imagine going up to the effigy and writing that message also so that it can be left there. We later use the Punitive Parent mode effigy in mode role-plays as a mask for the person playing the Punitive Parent mode. If we are doing a role-play where rage is being expressed, we do not have a patient play that mode; instead we drape the Punitive Parent effigy over a chair. Having this concrete figure allows us to literally throw the effigy out in experiential work. The figure can be stomped on and even torn apart. The therapists always take it away at the end of sessions. We keep it available in group sessions, but out of sight. All of these actions demonstrate and underline its powerlessness in the present to do harm. The Good Parent figure therapists can easily control this Punitive Parent mode.

### Therapist Tip: the Wizard of Oz

Joan has a favorite demonstration of the power of the Punitive Parent being an illusion. She holds the effigy up and compares it to the well-known movie character of the Wizard of Oz. She suggests that like the wizard, the Punitive Parent is an illusion, a screen that hides a powerless little character. She holds the figure up to full height and then lets it drop into a pile on the ground saying, “Like the Wizard, the Punitive Parent is all smoke and mirrors.”

Imagery work in which the group and therapists become a “protective army” can be developed to support a patient banishing their Punitive Parent. Mode role-play work is a good vehicle for work with the Punitive Parent mode. The Punitive Parent mode is not really a “parent”, rather the selective internalization of negative aspects of caregivers, which can be represented by an effigy and literally “cast out” —accomplishing the ST goal of helping patients eliminate this dysfunctional part of them. For those reasons, we think that role-play work with effigies representing the mode is the best fit

and a choice that makes maximal use of the group. On the other hand, when we are rewriting memories in imagery for the Vulnerable Child mode, we are frequently dealing either with parents or times when no parent was there to protect the little child. In that work it is a real historical person we are dealing with. We use the “army of protectors” image of the group at times for imagery work, but it is for protection from a person, not the construct of the Punitive Parent mode. We also prefer mode role-plays with the Punitive Parent as they are more forceful, involving everyone in an active way. We think that the movement involved can be a helpful outlet for the Angry Child mode.

Group Punitive Parent songs help scale the parent’s power now down to size and interject some fun and lightness for the Happy Child mode in the midst of doing such serious work. A song (Farrell, Shaw, Foreman & Fuller, 2005) that helps to scale the Punitive Parent mode down to a more manageable power and size is entitled “Creepy P.P.” It contains the lines:

I was thinking’ about the stinkin’ job you did for me when I was small –  
**and you were tall.** You didn’t have my back, instead I got a smack when all  
 I needed was love and hope – **you stupid dope.** But now I’m breaking free,  
 because I finally see that your crap was about – **you not me.**

The group sings it together, introducing an element of fun into the scary work of dealing with the Punitive Parent mode.

*Mode role-plays: integrating, cognitive, experiential, and behavioral interventions* As previously discussed, mode role-plays in group integrate cognitive, experiential, and behavioral interventions. We see this intervention as one of the most powerful in banishing the Punitive Parent mode effectively. The patient example in this section supports that assertion; as Karen was able to not only banish her Punitive Parent mother in effigy, but also to get rid of her voice, which had previously been diagnosed as a “command hallucination” by the referring psychiatrist.

We assess when the majority of the group feels safe enough to participate in or observe Punitive Parent mode role-play work. Punitive Parent mode work is an intervention where vicarious learning can be a helpful one step removed starting point. It is important for those in the Vulnerable Child mode without consistent access to their Healthy Adult to have adequate protection from their Punitive Parent and even the Punitive Parents of



others. Group members too afraid to confront their still powerful internalized Punitive Parent mode even symbolically can watch the activity and see that nothing bad happens to the therapists or peers. BPD patients, in particular those who were abused, if they are connected with their Vulnerable Child mode as we approach mode role-plays can be terrified, but also desperately need to be involved. Depending on the confronting patient's mode and need, the therapist and the group as a protective "army" can stand in front of the Vulnerable Child, or next to or behind the Healthy Adult mode of a patient for support, with hands on shoulders, holding hands, etc. This allows patients to begin speaking to their Punitive Parent from the safety of the group as the Vulnerable Child and in stages move into, then in front of, the group as their Healthy Adult gains strength. The tangible experience of the collective strength of the group effectively combating and eventually expelling the Punitive Parent mode concretely (using an effigy or other representation) has powerful effects in diminishing the power of this mode. We have seen patients begin in fear, take in the group's strength, and move in the same session to confronting their parent from the Healthy Adult mode.

It is also possible in group to set up progressive vicarious learning opportunities to get around what can be paralyzing fear, sometimes covered by Coping modes like Detached or Angry Protector. After observing other patients' role-plays from behind protective pillow barricades, a patient could observe the therapist and group play all of the roles in an enactment with his/her Punitive Parent. Patients are often afraid to play themselves, even with the support of the therapist as a Good Parent. They can have their role played by another group member, while they watch and listen, taking in the Good Parent's words, encouragement, and comfort. The therapists can play the roles of a patient's Healthy Adult mode and their Vulnerable Child mode, with the other patients providing protection. While observing, the patient should be in whatever degree of safety is needed, for example, safety bubble, covered up, or holding the co-therapist's or other member's hand. Over time, this patient can play herself protected by the group and/or therapists, and eventually play her Healthy Adult banishing her Punitive Parent mode. When patients play their own Healthy Adult, they can receive varying amounts of support and coaching from the group and/or therapists. Another benefit of group is that multiple options can be arranged, so that the needs of each patient can be met. Paying attention to meeting the needs of all provides another group experience of validation and a demonstration of how everyone's need can be met in a healthy family where no one is sacrificed.

Although we use filled chairs in these role-plays, we do introduce an element of distance for the role of the Punitive Parent mode. We use the effigy that the group constructs in an earlier experiential exercise as a kind of “mask” for the person playing that role. We do not want any residual Punitive Parent energy attached to the patient who plays that role. We want the Punitive Parent to remain something “not human” that was taken into the Vulnerable Child and needs to be eliminated. We do not have either therapist play the Punitive Parent mode role. We had some debate about this position with drama therapists in a training workshop who thought that any role could be removed at the end of the “scene.” We had them try playing the Punitive Parent in a group role-play to investigate this. After doing so, both therapists said that they now understood what we meant and agreed with our position. They felt what we had in developing these exercises; it just does not feel right as a therapist who has worked to be accepted by patients in the role of Good Parent to take on the Punitive Parent mode role. Inevitably the Vulnerable Child mode of the patient is involved and the cruelty of the Punitive Parent mode role does not seem in any way therapeutic to us. It could be different with higher functioning patients, but with BPD and other severe personality disorder patients we do not recommend it. On the other hand, there is therapeutic value in having other patients play that role and they usually find it very easy to do. They end up playing their own Punitive Parent and realize two things: first, the common features of all Punitive Parents, and second, as they try on that role they feel how extreme the parent really was. The latter comes from their ability to empathize with the other patient for having such a horrible Punitive Parent mode. In contrast, their compassion for their own little child is often limited. This mode role-play with a patient as parent provides an opportunity to point this out and do some much needed work on self-compassion.

Be sure to check after Punitive Parent mode work that group members feel safe before leaving the session. Create contingency safety plans if they have safety concerns. Finish the session with a longer return to the Safe Place image or Safety Bubble that includes the instruction that the Punitive Parents are safely locked away with the Good Parent therapists.

### *Getting rid of Punitive Parent voices*

As a result of banishing a Punitive Parent mode in mode role-play work, patients have sometimes reported that a voice they used to hear condemning

them was no longer there. This happened with one young woman, Karen, who came to us with a schizoaffective diagnosis and a report of “command hallucinations.” Her voices were ego-dystonic; she was extremely distressed by them and visibly suffering from this experience. Karen met criteria for a BPD diagnosis, but at times we thought that her “voices” went beyond the transient, stress-related psychosis of BPD. She had difficulty accepting our efforts to label them as Punitive Parent mode manifestations, although she did not consider the voices part of her.

### Karen’s Punitive Parent mode: Step One

In a group session where we were working with the Good Parent script exercise, as patients came back to the group and opened their eyes, Karen began rocking and sobbing, saying, “Why don’t I have a Good Parent? Why doesn’t my mother love me? And why does she blame me for my stepfather molesting me? She said I wanted him and it was my fault that it happened. She said that I was destroying her happiness. I didn’t even like him. Why did she kick me out and believe him?” A patient sitting next to her offered a hug, but Karen didn’t want to be touched. Joan asked if she could move over and sit by her, and Karen said “Yes.” Joan just leaned toward her supportively, but not touching, given what Karen had said. Another patient gave her a glass of water. The group said many positive, loving things to Karen, as she is a very likable, caring young woman who was well-liked by her peers. She rocked and sobbed some more, saying “Why does no one love me? What is wrong with me?” Our plan for that day was to write the Good Parent messages on cloth for permanence for each patient. One of the group asked Ida if they could write one for Karen. She validated what a good idea that was, so they began passing a cloth around to each of them. Karen was very touched when it came around to her. She asked for hugs from peers and the therapists as she said she now felt worthy to receive them. She also said that even though her family did not love her, she felt loved by the group.

This example illustrates the need to be ready in a group for a quite different reaction to an experiential exercise than you anticipated. The group used this productively as they all thought Karen very lovable, so it made the point that a parent’s behavior and a child being worthy of love are independent.

Of course, the therapists underlined this message and referred back to this experience as evidence when other patients verbalized the belief that their Punitive Parent's treatment meant they were bad. This is easily done by saying, "Wait a minute, I thought we figured out and you agreed that the way Karen's (and put in the names of other patients who have done Punitive Parent work) mom treated her, did not mean Karen was bad. Why would your mom's treatment make you bad?"

### Karen's Punitive Parent mode: Step Two

The next week in group we did some mode role-play work to banish various Punitive Parent modes of patients. At the beginning of group during a mode check-in, Karen said she was in Healthy Adult mode. She was smiling and looked cheerful, telling us, "I no longer think I am to blame for the abuse. It took me 29 years, but finally last week it sunk in, that it wasn't me who was to blame". We were all very happy for her. She asked if she could banish her mother today, as she felt ready to do that. We used our Punitive Parent mode effigy with another patient playing her mom and patients supporting Karen. She did a strong job of telling her mother, "You are wrong, you should have protected me. You don't have anything that I want now, I have people who love me here," etc. At the end of these mode role-plays the patient can throw the rolled up effigy out of the group if they want to. Karen did this. She appeared unburdened and Joan commented on this. Karen said that for the first time she felt free of her "mean mother" and that maybe she was "lovable."

### Karen's Punitive Parent mode Step 3

The following week Karen told us that she was very troubled again by her "voices." In exploring this briefly we discovered that there were now only two voices – both male, the female voice was gone. Some inquiry revealed that the female voice had been gone since the "banishing" of her mother. There was a flash of insight for Karen and the group that banishing her mother got rid of her voice also.

We give this example to make the point that sometimes when we do the cognitive and emotional work, the behavior change follows on its own. For Karen this was the case. Her “mean mother” voice had not returned when we last checked 9 months later. It also is a clinical example of how much effect experiential work in ST can have.

*Behavioral pattern breaking* The behavior change component of GST needs repetitions of catching Punitive Parent mode messages, questioning and discarding them. Group is an ideal place for this to occur as there are nine people listening who will label the Punitive Parent voice if it is missed by the one affected by it. Patients can concretize their army with drawings that they display in strategic locations to remind them of the group experience in which their Punitive Parent mode was banished.

We also have exercises at the concrete operational level of emotional development to use with patients. The miniature parent effigy exercise is one such intervention that aids practice outside of sessions.

### IDA's small Punitive Parent effigy example for behavior change

#### *Miniature parent effigies exercise and homework*

Patients can make miniature versions of the effigies with sheets of paper – one of the Punitive Parent to write critical messages they hear on, and one of the Good Parent to write some of the messages they would like to have heard. They fold them up and put them in separate pockets, a purse, or binder. Any time during the group when the Punitive Parent mode surfaces, we stop the action and ask, “I think I hear a mode, does anyone else hear it?” Patients are usually good at hearing the Parent modes of others, so after one of them answers, we ask the patient if they are aware of that mode operating and what is the message. We ask for their Punitive Parent note and put it out of sight, declaring, “No Punitive or Demanding Parents are welcome here, only Good Parents welcome.” This action is followed by taking out their Good Parent note to read those messages. At the end of the session we tell them, “We all need practice banishing our Punitive Parent mode. So, when you are at home and you are aware

that the Punitive Parent mode is operating, get the paper and put it in a more secure spot out of sight and then read over your Good Parent messages.” Patients like this exercise and report good results. The action of “locking up” the Punitive Parent representation seems to give them a sense of control – that they are doing something, instead of feeling helpless and controlled as they did as a child.

We use the Steps in Mode Change Plan (BEH 3-2) and Mode Management Plan (BEH 2-4) for the Punitive Parent mode. We also use the Antidote form (BEH ANT 3) to summarize Punitive Parent mode change work.

### *The Demanding Parent mode*

The goal with this mode is setting realistic limits to replace the Demanding Parent. The steps and techniques for replacing the Demanding Parent mode are similar to those used for the Punitive Parent mode. The experiential interventions of constructing an effigy, the mode role-plays, and the miniature individual Parent effigies are all used. The cognitive interventions of flashcards, pro and con lists, etc., are all part of the work. The same practice strategies used for the Punitive Parent mode with behavioral pattern breaking interventions are also employed. The main difference is that while the Punitive Parent mode serves no positive purpose, as punishment is not necessary, the Demanding Parent needs to be made reasonable, not eliminated. We don’t encourage debate or argument with the Punitive Parent mode, just elimination. With the Demanding Parent mode some negotiation and change are involved. We don’t want to eliminate drive, ambition, and high standards; rather, we want to eliminate drive that excludes other aspects of life such as pleasure and that demands unrelenting and unreachable standards. It is important for patients to become aware of the Demanding Parent mode beliefs in their self-talk and to see it as not necessarily reflecting their own beliefs and values. This is accompanied by discussion in group about how to find a balance and healthy standards that match one’s abilities and desires. Group praise and admiration for their positive qualities and accomplishments can be ammunition to use in getting the Demanding Parent mode under control. The therapist’s voice and messages can be used as a bridge from the Demanding Parent (which is all they have known) to claiming their Healthy Adult voice.

Many therapists have a Demanding Parent mode that they still struggle with, who might sometimes interfere with them enjoying their accomplishments to the fullest, but may also have been one of the things that got them to finish years of school and clinical training. Interestingly, it is the Punitive Parent mode that goes away faster in ST. The Demanding Parent mode hangs around longer, but by the end of the treatment program it is also reduced significantly. By Year two of ST the patients are replacing the Demanding Parent mode with their Healthy Adult voice, who can use healthy self-talk relatively free of unrelenting standards to motivate themselves effectively and both give and accept praise for good performance. We often describe this to patients as accepting the concept of “good enough” and that it is “good.”

### **The Healthy Adult mode**

This is the mode that functions as an executive to make the changes in putting aside the Maladaptive Coping modes to claim the expression of feelings and needs; the part of self that cares for and protects the “little child” and banishes the leftover Punitive Parent of childhood. It is into this mode that the Angry Child is channeled into healthy assertiveness and the mode that sets limits on the Impulsive Child. The Healthy Adult has been present and being strengthened throughout this chapter given his/her central role in this work. It is important that this mode be engaged at the end of outpatient group sessions to ensure the safety of BPD patients between sessions. This can be done by including this mode in the ending safety imagery, pointing out strengths and abilities and connecting the Healthy Adults with the support of the group. An example would be to have the patients take hands and ask them to feel the strength of the group circle and all of the resources and competence available in the group to back-up their Healthy Adult. The second year of treatment is focused on the Healthy Adult mode and is discussed in Chapter 8.

# The Course of Group Schema Therapy

## Stage Three: Autonomy

J. M. Farrell and I. A. Shaw

### **Healthy Adult Mode Work: Summary of Mode Change Work, Behavioral Pattern-Breaking, Stabilization of Identity**

Year two of Group Schema Therapy (GST) focuses on the application and strengthening of the changes made in Year One and the consolidation and anchoring of this therapeutic work in the Healthy Adult mode. This mode, which is weak and under-developed when BPD patients begin Schema Therapy (ST), has been developed and strengthened by the group's awareness, cognitive, experiential, and behavioral mode change work of the first year. The Punitive Parent mode has much less voice, the Demanding Parent mode more reasonable and the Good Parent of the therapists has been internalized. The Child modes are being integrated into the Healthy Adult mode. The Healthy Adult mode handles executive functioning in the following ways: the Vulnerable Child part has experienced healing and his/her needs are met, the Angry Child has been channeled into assertiveness skills, the Impulsive/Undisciplined Child has healthy limits, and the Happy Child is available with his/her spontaneity, creativity, and joy. Behavioral pattern breaking work is ongoing from the Healthy Adult mode and moves into the interpersonal arena. The Year Two issues are: adolescence to adulthood, identity, autonomy, healthy interpersonal relationships, hopes and dreams, and graduation from GST.



*Summary and review in the group*

As the course of GST above suggests, by the end of Year One patients have a good understanding of ST, their experience of the modes related to Borderline Personality Disorder (BPD), and an understanding of their life problems in terms of the mode model. They will have done a considerable amount of experiential healing work for the Vulnerable Child mode and have developed access to a stronger Healthy Adult mode to soothe the “little child” part of patients when needed. The use of Maladaptive Coping modes, like Detached Protector or Angry Protector, will have been replaced in large part by healthy coping and the ability to stay present to experience emotions. The Punitive Parent will have been banished in experiential work and its evaluations rejected. Work will be going on to modify the Demanding Parent’s expectations, unrelenting standards, and constant driving to be the best.

To summarize Year One and move into Year Two we review the following set of goals with patients. We emphasize that we do not expect all of the first 16 goals to be completed, rather that work is underway. We also stress that there will be back and forth movement among the various foci and goals over the next year. In our protocol, the second year of group meets weekly for approximately 6 months then biweekly for 3 months and monthly for 3 months in a phasing out process supportive of patients increasing autonomy.

**The course of GST for BPD**

To recover from BPD, a person needs to complete the following steps, not necessarily in this order.

1. Understand BPD symptoms and their experience of it.
2. Understand schema and mode concepts.
3. Be able to identify their experience of the various modes, mode triggers, and when a mode starts.
4. Understand healthy childhood needs and the origin of modes from unmet childhood needs.
5. Be able to identify the unmet need underlying a mode. Be able to take healthy action to get this need met, first in the group or with their individual therapist, and later by close others and their own Healthy Adult.

6. Understand their main schema triggers for modes. Have some doubt that the core beliefs related to their schemas are the same as “facts” or healthy consensual reality.
7. Recognize Detached Protector. Complete pro and con lists to evaluate the decision to allow feelings to occur in therapy.
8. Understand that they can learn to recognize the beginning of unhealthy Coping modes and make the choice to stay present and be in the Vulnerable Child mode safely without bad outcome.
9. Understand the Dysfunctional Parent modes and be able to see them as the negative aspects of caregivers that were internalized, and not themselves.
10. Have the courage to be present when therapists and group set limits with the Parent modes. From the Healthy Adult, be able to talk back to the Punitive Parent and/or Demanding Parent in defense of the Vulnerable Child. Limit the Punitive Parent mode’s influence and eventually banish it. Replace the Demanding Parent with realistic expectations and standards.
11. Gradually experience the feelings of the Vulnerable Child using progressively less detachment, to balance fear. Develop compassion for their “little child”.
12. Participate in imagery change work focused on healing the Vulnerable Child. Develop and use Good Parent images that are eventually internalized and become part of their automatic self-soothing. Eventually replace unhealthy Coping modes with healthy meeting of needs and imagery work.
13. Be able to connect with Vulnerable Child mode and accept healing reparenting from the therapists (nurturing, comfort, love, guidance, etc.) and support, acceptance, and belonging from group members. After these healing experiences of having Vulnerable Child needs met, learn to take over this role from the Healthy Adult mode.
14. Be able to identify the needs of the Angry Child and Impulsive Child modes and understand that the need is legitimate, but the method of meeting it can be faulty. Understand the origins of their child modes. Evaluate the negative consequences to relationships of allowing these child modes to be the way they meet needs. Ask with words rather than communicating with actions.

15. Learn to recognize the beginning of Angry Child or Impulsive Child modes and be able to channel that energy into assertiveness, problem solving, and other Healthy Adult skills.
16. Be able to access and/or develop their Happy Child. Through play learn about their likes and dislikes, interests, enjoyments, and positive interactions with others.

The following goal is the main work for Year two:

17. Healthy Adult mode must be accessible most of the time. The Happy Child must have time to play and celebrate life. Vulnerable Child wounds have healed (or are in the process of healing) and his/her needs are understood, met, and protected by the Healthy Adult. Angry Child mode is channeled into Healthy Adult action to get needs met. Impulsive Child mode has limits. Unhealthy Coping modes occur only rarely, if at all, and only in crisis situations. Punitive Parent is banished and Demanding Parent is replaced with healthy standards that are realistic and allow for healthy positive self-esteem.

They will have an overall plan like the one shown in Table 8.1 for the Child, Maladaptive Coping, and Dysfunctional Parent mode groups.

*Defining positive identity “out of the rubble of schemas and modes”* The maladaptive modes distort the development of a Healthy Adult identity. The Child modes are regressive and are the source of difficulties with interpersonal relationships, in particular the Angry and Impulsive Child modes. We see Detached Protector, the most frequent BPD coping mode as one source of the painful emptiness patients feel. It disconnects a person from their feelings – an extremely important source of information about the self. The Dysfunctional Parent modes distort identity with their negative, unrealistic, and unrelenting evaluations of self and performance. Consequently it is only after the influence of these modes has diminished in intensity and frequency that the core self of a patient can be known. At that point two things are important: (1) that healthy characteristics and qualities which may have been negatively evaluated by the dysfunctional parent can be reassessed and possibly claimed; (2) that a person has more information about their true likes, dislikes, interests, and fulfillment. This is the stage of ST in which a person

Table 8.1 Example of vulnerable child mode problem summary

Schema mode	Schema triggers	Your problems/ issues related to this mode	Do you flip? To which mode?	How are you working on this?
Vulnerable Child	Feeling hurt. Remembering how Mom treated me. Remembering abuse. Being talked to in a loud or mean voice. Feeling abandoned or scared.	Feeling hurt about something in the present brings up a lot of old hurt feelings and my Vulnerable Child cannot tolerate having these feelings.	Yes, sometimes I flip to Impulsive Child.  Sometimes I flip to Punitive Parent. Sometimes I flip to Detached Protector.	<b>Identify need:</b> to feel cared about. To feel I have stability and safety. <b>Ask (therapists, group) for help with need:</b> I could ask for a hug, or for someone to sit with me. <b>Access your HA for help:</b> <i>example: Do a circle to access your HA (cortex)</i> My Healthy Adult could get a soft blanket to wrap up in and my bear to cuddle. I could rock and remember Grandma hugging and rocking me.
Angry or Impulsive Child	Feeling that I cannot stand the feeling for a minute more.	In this mode, I cut myself or swallow, anything I can to end the scary hurt feelings.	Impulsive Child mode	I need to ask others for help to stay safe – like not to have anything unsafe near me and not to have objects to swallow.
Punitive or Demanding Parent	This flip gets triggered if I hear my internal parent voice say it is my fault or I am bad.	In this mode, I hurt myself as punishment for feeling, being “weak”	Punitive Parent mode →	I need Good Parent protection. I could talk about what I feel with someone who will reassure me that I am good. I could access Healthy Adult mode and use the soothing image we worked on in group or read Good Parent cards.
Coping mode	This can happen automatically when I get to a high intensity or overload.	In this mode I may self-injure later- to feel something, if it gets too scary to feel numb. I can start to feel unreal.	Detached Protector mode ↘	I need to reduce my hurt feelings. I could vent my feelings. I could use healthier detachment like my safe place or safety image. Awareness that I am getting too distressed is important to stop Detached Protector.

with BPD begins to know his/her true self. A related topic of importance for group discussion is, “What are your hopes and dreams?” Our patients are without many answers to this question as they never thought that they could either hope or dream. Limited reparenting in this stage of treatment consists of guidance in exploring questions like this – something patients did not receive in childhood. We use the following exercise/homework to further assess lingering effects of Modes and childhood experiences.

### Clarifying your Healthy Adult identity

Unstable identity is one of the problems that people with BPD struggle with. Over the last year in group sessions you have learned about the schema modes or parts of yourself that you have that are related to the way your childhood needs were met and not met. The first step in clarifying an accurate Healthy Adult identity is to identify the parts of your identity or self-image that are related to maladaptive modes, assess the place they have in your identity, and reevaluate whether they belong or not.

One of the common damaging messages from the Dysfunctional Parent Modes is that if you are not perfect, then you are defective. We looked at that message previously as an “all or none” cognitive distortion. This message takes a lot of forms. Some are: “I am bad, unworthy, a loser, not good enough, etc.” If you struggle with that message or a related one fill it in here:

Next we will take a more neutral Healthy Adult look at the accuracy and validity of that message, by reviewing the following information:

1. **Information from your circles** that gives basic information about you. For example, what are your successes and accomplishments? This provides current life information.
2. **Negative thought/cognitive distortion information.** This information will probably be in your thoughts section of circles. An example would be the thought, “I am a loser” or “I never get anything right.”
3. **New positive facts.** Here is the place to put in positive feedback you get from others such as peers, therapists, and staff. These are “facts” about you that you can work to accept and that can

actually come to replace the distorted facts from your childhood. We accept when we are growing up the “facts” given to us by our parents and other people important to us. Why not reconsider the “facts” that you accepted as a kid who knew no better and who had no positive adults to give more accurate feedback? Why not work to take in facts about yourself from less biased people – like your group leaders?

4. **Messages that come from childhood.** Negative Dysfunctional Parent mode messages have roots in childhood experiences. Usually this is some kind of abuse, emotional deprivation, not feeling loved, parents who were absent or not able to be loving, etc. In abuse situations, abusers typically project their badness onto their victims. They unfairly and erroneously blame the victim for the abuse. It is too scary for children to think that their parents are bad or unable to love. If they accepted those facts, it would mean that the abuse would never stop and they would never get the unconditional love they want and need. So, kids think that if only they weren’t “bad” or if they were “good enough” then abuse or neglect would not happen and they would be loved. Unfortunately, in this situation it doesn’t matter how perfect the child is – she/he still are not loved. This is not the child’s fault. An aftereffect of not being loved and validated as a child is that as an adult you may continue to look to emotionally unavailable or abusive people for love and approval. This self-defeating quest is an example of a “life trap.”

(HAM 1 to 8)

Antidotes to the defectiveness schema include:

- Identifying the foundations of this negative belief and re-evaluating and correcting any distortions (refer to Chapter 7 for work to limit the labels from the Punitive Parent).
- Learning to love and accept yourself by making peace with past mistakes and having healthy and reasonable expectations for yourself.
- Taking in the validation and acceptance that are available in your environment and protecting yourself from rejecting or negative people.

*Summary of childhood contributions to identity*

The ST group plays a formative role in unfinished identity formation. Identity is formed in part by internalizing early significant others' view of us. The group can provide new and more accurate reflections of the patient that correct the faulty distortions they internalized as children.

*Vulnerable Child mode work for the Healthy Adult***Developing your Healthy Adult as an ally for  
your Vulnerable Child**

How can your Healthy Adult make use of what you know about your Vulnerable Child's needs?

We will discuss this in group today and then we want you to work on a plan to use and practice implementing that plan this week.

For example, if you know that a particular situation triggers painful memories for your Vulnerable Child, you can figure out ways to prepare her/him for that situation if it cannot be avoided. You can possibly negotiate changes in the situation to scale down its difficulty level or threat, limit your exposure, take soothing objects with you, use some healthy self-talk (Good Parent voice) before and during the situation, etc.

MY PLAN IS: \_\_\_\_\_

Results of using this plan: \_\_\_\_\_

Changes my plan needs, or refinements that I became aware of: \_\_\_\_\_

**Adolescence***The group is an ideal setting for adolescent level mode work*

As the life of a ST group continues, young child schema mode issues are healed and the group's focus turns to issues of later childhood and adolescence – separation, individuation, and identity. ST groups can serve as a close analog for the missing adolescent “peer group” experience of patients

with BPD and thus play a healing role in unfinished identity formation. Because of invalidating or abusive childhood environments, most patients with BPD were either prohibited from or had schema issues that interfered with connecting or developing a sense of belonging to a healthy peer group or even any peer group at all. Often in abusive homes little contact with the outside world is allowed. This deprivation of potentially healthy input regarding self from outside is particularly destructive for adolescents who do not have a solid earlier childhood base of feeling worthy and loved. Adolescents are desperate to belong somewhere, which leads them to attempt connection at almost any cost. Defectiveness schemas may lead to alliances with negative peer groups that encourage substance abuse, criminal behavior, and running away from home. They often begin unhealthy romantic and sexual relationships in adolescence in an effort to fill their emptiness. They may cope with the experience of unmet adolescent needs by the additional survival coping modes of Avoidance, disconnecting in Surrender to social isolation schemas, or rebel in an Overcompensating rejection of healthy society as well as their unhealthy families.

Adolescence is also the developmental period in which healthy separation and individuation occurs. The focus becomes exploring and reaching an understanding of the larger world outside the family, contemplating what place one wants to have in it, and what the meaning of one's life is. The relational need here is to have people to discuss and explore this process with. In addition, it is difficult to "push away" from parents if there is no peer group to transition to. In healthy development, it is a time to make decisions about what kind of friends you want and to begin to consider what kind of romantic partner you will find a fulfilling life with. Overall, it is the beginning of preparation to leave the childhood home, and involves a focus on life outside the family of origin and movement towards forming one's own family. Most BPD patients we see in treatment have not answered the questions of adolescence or figured out what gives meaning to their lives, what makes life worth living for them. This deficit is part of what accounts for their high rate of suicide and even higher rate of suicide attempts. The therapy group can provide another opportunity to transition to a Healthy Adult mode and life with healthier support. Schema therapy has focused until recently on the early childhood stages of identity development and corrective emotional experiences which fit the reparenting relationship of individual ST. GST offers that relationship (and with two therapists there are more parents) to meet early attachment needs, and opportunities with group members to explore later stages of identity development. The group's



ability to be a naturally occurring laboratory for these later developmental learning experiences in addition to the role it plays in earlier stages, facilitates strengthening the Healthy Adult mode and may be one of the reasons for the large effect sizes found in the group randomized control trial of Farrell et al. (2009).

### **The Therapy Group Provides Corrective Learning Opportunities for Identity**

Unstable identity is a core deficit in patients of BPD that underlies feelings of emptiness, abandonment fears, and difficulties with interpersonal relationships. We develop our identities by internalizing feedback (reactions to us, labels, descriptions, positive and negative defining experiences with others including acceptance or rejection, etc.) from important caretaking figures in early life and from our peer group in adolescence. ST addresses this BPD deficit through schema mode work in which disconnected aspects of self are healed or transformed and ultimately integrated into a strengthened Healthy Adult mode. Early identity work for the young Vulnerable Child can be effectively accomplished in individual or group ST. The therapist can provide information about normal childhood needs against which patients can re-evaluate their childhood experiences and the expectations and reactions of their parent/caretakers. Patients learn a lot about themselves from getting through Detached Protector mode enough to explore their real wants, needs, likes and dislikes, and understanding that these were and are healthy despite being different from those dictated by emotionally depriving or unhealthy family situations.

#### *Cognitive interventions*

##### *Assessing the Healthy Adult mode*

#### **Healthy Adult Assessment Exercise**

The Healthy Adult is the part of you who is able to use cognitive and experiential antidotes to schema modes that you struggle with. Your Healthy Adult is the part available to provide for the needs of your

Vulnerable Child. Your Healthy Adult is what allows you to break through the unconscious boundaries that schema issues throw up to interfere with you using your own strengths.

1. Write about your Healthy Adult as she/he exists today. For example, what strengths are you aware of?
2. What percentage of your identity does Healthy Adult represent? (0–100%) (We use the Mode Pie Chart)
3. How do you access your Healthy Adult and how would your future be different if you had consistent access to your Healthy Adult?

To help with the Healthy Adult Assessment Exercise, we give patients the following description of aspects of the Healthy Adult mode and Stable Identity.

### Your identity: The Healthy Adult mode

Here are some ways to assess the different aspects of your Healthy Adult Mode.

Read these over, think about where you are with each aspect, and be prepared to discuss this in the group session. Pick one aspect that is a particular issue for you and write about it.

A stable sense of Healthy Adult mode and identity includes the following:

1. You have an awareness of inner beliefs, needs, values, and feelings.
2. You feel a sense of “ownership” of inner needs and feelings. You experience that these happen within you, not to you.
3. You can retain your values, beliefs, feelings, and needs even when in the presence of powerful others.
4. You are able to make clear statements of your inner feelings, beliefs, and needs without apologizing, minimizing, or being reluctant.
5. You have a constant inner sense of “I” or “Self” across all situations and circumstances. You are not confused about how you really feel or what you want.

6. You pursue personally meaningful goals, living in accordance with inner desires and values – your life is not chaotic or undirected.
7. You have an inner sense of “centered-ness” especially during stressful times.
8. You have clear self–other boundaries. You are able to be connected, yet also maintain autonomy.
9. You are able to generate feelings of worth from within – you don’t rely on others to provide reassurance of your worth.
10. You can take an assertive stand on things that matter.
11. You can trust your intuition and feelings – while being aware that you might have a tendency to discount them because that is how you were raised.

HAM 5 presents one of the patient forms that we use to summarize identity information with its source. HAM 6 gives the instructions for completing it.

### *Experiential interventions for the Healthy Adult mode*

#### **Group Exercise: Developing Your Healthy Adult**

One major way to develop your Healthy Adult mode is to strengthen the *reminders that support positive thinking, coping, and a plan for the future*. Many different kinds of things fit in this category: a supportive relationship, a picture of a supportive person, a picture or symbol that represents an important characteristic you have, a note of encouragement, etc. Strengthening your positive life plan is the best counter for suicide plans.

**ASSIGNMENT:** Identify, and then try, at least three of the following kinds of “Healthy Adult Strengthening strategies. Write about what you chose and your experience with doing it.

1. Use encouraging words from others that you have written down. If you don’t have any, ask people for some.
2. Practice a healthy coping skill.

3. Hold a tangible object, smell a scent or look at a picture that evokes a feeling or positive connection.
4. Visualize positive memories. Imagine that your mind is like a slide projector – put in a positive slide of a memory and if a negative slide shows up, eject it and put the positive one back in. Remember that we don't have conscious control of every thought that comes into our heads but we can do something about whether we let it stay or replace it with something else.
5. Visualize a dream you have for a healthy adult future.

*The identity bracelet* At the beginning of Year 2 and at the end of the Group Schema therapy Program we devote a group session to what our patients have named the “Bead Experience”. The instructions and an example are given here.

### Identity Bracelet Exercise

An example of a creative group exercise we use experientially to impact the defectiveness schema so common in patients with BPD and to strengthen the budding positive identities of our patients involves making an Identity Bracelet. In a group session, the therapist provides a selection of various beads and group members and therapists select a bead for each member that represents a personal characteristic of him or her that they like or value. The Identity Bracelet for each person is built by group members taking turns presenting a bead and making a statement about what it represents. This process continues until all patients have a completed bracelet.

The therapist then leads an imagery exercise that includes feeling the bracelet on one's wrist, going over in visualization the experience of receiving the beads with the instruction to let the bracelet represent and anchor in memory those positive feelings. This experience can then be recalled with the therapist or group's help.

When we first tried the “Bead Experience” we added some preventative instructions. Before we began, we had everyone list a strength or positive characteristic that was important to them, or they valued, and felt they possessed or were working on. Ida wrote these on the

whiteboard with each member's name. Joan then told the patients that they could either choose one they observed in their peer or use the one listed on the board. Usually patients are quite eloquent in what they say to each other and to us, even preparing it in writing ahead of time. It did not seem like the patients needed our back-up plan, but it made us feel better to have it in place.

### Patient example

In a later group session, a group member was talking about how she “knew in her head” that she was not a hideous monster, but she “felt like one.” She was asked to recall the bracelet experience, and a smile came to her face as she extended her wrist with the bracelet on it. We had her put her other hand over it, close her eyes, and recall the experience as fully as possible. She was able to do this and the positive feelings of acceptance and value that came to mind combated her old feeling of “being bad” and even capable of “contaminating” anyone she touched. This use of the bracelet was repeated many times and the group as a whole was given the assignment of touching the bracelet and recalling the experience at times when the Punitive or Demanding Parent threatened to disconnect them from others. The group bracelet representing positive peer group feedback became a physical anchor upon which to build a more stable positive identity. Before this experience, Jill would infrequently leave her home because she feared being pointed to and called names as she had been as a teen in a small rural town. This is an example of using the therapy group to heal Adolescent mode Vulnerable Child experiences. In this example, a tangible object that represented the experience of being accepted and cared for in a peer group broke through to a patient usually locked in Detached Protector with a vicious Punitive Parent berating her defectiveness. Jill's dramatic facial transformation from pain and no eye contact to reflexively touching it while looking up and smiling when reminded of her bracelet is evidence of being affected at the emotional level. This reaction continued whenever she was reminded of the bracelet and she was still wearing it when discharged from the hospital. Many of our patients continue to wear their bracelet.

This is also an example of using transitional objects from the group as part of healing. It is reminiscent of the behavior that we see with chronological adolescents who often trade pieces of jewelry or clothing with “best friends” as part of the bonding and identification process that underlies identity formation. Group relationships can be opportunities to have the defining “best friend” relationship that is another part of adolescent identity formation. We see this acted out particularly in the inpatient BPD ST groups. We observe frequent occurrences of group members giving each other inexpensive pieces of jewelry, wearing the same T-shirts in group, even getting the same haircut, and interpret this as additional clinical evidence for the process of adolescent stage identity development being re-enacted in the structure of the “sibling” schema therapy group.

*Learning about interpersonal relationships* The advantage offered by the group as a microcosm of the larger world was discussed in Chapter 3 as one of the therapeutic factors of GST. This makes it a safe environment to get feedback and practice skills that can strengthen the patients under-developed Healthy Adult mode. The group can be a base for these rejection-sensitive people to grow from. Indeed, the words “home base” aptly summarize what the ST group can provide, extending the “family” aspect of limited reparenting. Patients are often more able to risk expressing needs including boundaries to peers who they know understand and experience modes. The emotional experiences of people with BPD are arguably of a different character and intensity than those without this neurobiological sensitivity and greater reactivity. Their unique experiences in interpersonal relationships and their potential for negative distortions of the meaning of others’ behavior combine to require a controlled experience with validating others to facilitate the healing schema change that they need. Such healing does not occur naturally in adult life or in mixed psychotherapy groups where these rejection-sensitive people may once again feel misunderstood and be ostracized due to their extreme behavior. We are not suggesting that all the social interactions of patients revolve around their therapy groups, but people with BPD rarely have healthy friendships when they come to treatment, and group relationships can be stepping stones toward other healthy adult relationships. We expect that as the Healthy Adult mode is strengthened, patients will be able to expand their social networks.

The example here illustrates the patient’s growing ability to identify the role of “schema chemistry” and to make a new decision in an interpersonal relationship.

### Patient example: Schema Chemistry in relationships

Another opportunity for in-vivo work of learning about connection can occur in the context of group relationships. Before treatment, patients may be drawn to friends and romantic partners more by schema chemistry than good fit. Strong connections in group are often formed initially based upon schema chemistry can be opportunities for learning about connection and how to make active decisions about the health of a relationships for you. These relationships can be examined and renegotiated with the help of the group to grow and become healthier. One example from an inpatient group was the friendship between Sam and Ann. Sam coped with the fear, loneliness, and lack of love of his Vulnerable Child from surrender to self-sacrifice and subjugation schemas, and the anger and feelings of being used of his Angry Child mode with Detached Protector. In the Detached Protector Mode he made suicide attempts. Sam had no relationship with an absent father and it was his mother who this mode determined relationship was with. Through the course of ST, Sam made many healthy changes in relationship to his mother. However, he was also drawn by strong schema chemistry to a fellow patient who was very much like his mother. He connected strongly with Ann, who was often in Vulnerable Abandoned Child mode, expressing needs for comfort and care that were at an early developmental level and often physical. When she underwent knee surgery, Sam stepped in to take care of her with attentiveness that approached catering to her “every whim”. They quickly made plans to live together in a platonic relationship after hospital discharge. Sam became aware that as Ann recovered from surgery and needed him less physically, he felt less connected to her. He verbalized that he felt like the relationship was over and identified this as the usual pattern of his relationships – attracted by need, then as the need waned the relationship died. He realized that in childhood he had an enmeshed relationship with his mother who was unhappily married to his distant father. When he was a young teen, they divorced and he became her main confidant and caretaker. When he was an older teen she remarried and he was forced to leave home due to the new husband’s abuse. Sam described feeling like he had no meaning, purpose, or connection with Mom after that. He solved the emptiness he felt with substance abuse and occasional

swallowing of foreign objects that led to medical hospitalizations. As he came to understand the pattern of his schema modes and the role of his history, he re-examined his current “best friend” relationship and asked Ann for a healthier connection that included his needs and some reciprocity. This caused initial conflict between Sam and Ann, followed by some maturation in their friendship as they processed it in group sessions. Ultimately Sam decided that living with Ann was a bad idea as he was still too prone to succumb to the pull to deny his needs and care for her. Ann realized that she too frequently asked him to be her Healthy Adult instead of developing and accessing her own.

This is a good example of how the limited reparenting approach of not attempting to prohibit group friendships rather standing on the sidelines identifying mode issues and giving feedback when asked, like a Good Parent, can generate significant schema mode change. In general, when there is no foreseeable harm from a decision a patient is making, we will respond with our perceptions, but not take stronger action to deter a patient’s action. For one thing, we do not have the power to do so. We remain in a supportive role, allowing them sometimes to learn for themselves how a decision turns out and to make a better one next time. This applies to the Sam and Ann example. It was clear to the therapist team that if we took an overt stand it would have been likely to evoke resistance that brought them closer together “against the parents.” On their own, they figured it out and learned from the process of going through it.

*Graduation or “abandonment”* It is possible to make the end of the active group stage of ST a “graduation.” The separation phase of GST occurs in a series of graduated steps that parallel the patient’s growing autonomy and feelings of hope and competence. Skills and improved interpersonal abilities learned and practiced in the group begin to generalize to life outside of therapy. New healthy relationships are formed outside of the therapy group. Transitional objects from the therapists and the group can be used to support movement to autonomy while maintaining connection.

It is important both to focus on the end of this phase of patient’s treatment as a graduation while being willing to validate and discuss their experience of abandonment feelings. The second GST group that we led was of necessity (NIMH grant schedule) eight months long. We knew that it would be



important for us to deal with any abandonment issues patients had as the group neared its conclusion, but were apprehensive about bringing up the subject. Our patients brought it up for us when they were ready, which was about 6 weeks before we ended. This was one of those therapist learning experiences for us that we now refer to as “acknowledge the elephant in the room, because the patients see it.” We discussed with the group what their fears were and found that they were rather vague. We changed the question to one they were familiar with us asking them, “What do you think might make you feel less abandoned?” This was easier for them to answer. Some of the things that the patients said helped them with feelings of abandonment were: personal, handwritten note cards from the therapist, a photo of the group, the addresses and phone numbers of other patients with the promise to update as needed, a plan for the group to get together for lunch at a scheduled time after the last session. We checked in on the topic every week until the last session.

### **Support Groups for Patients with BPD**

We think that a patient led support group after a two-year ST treatment program would be ideal. It would give patients the opportunity to continue to make use of the strong resources of the group while proceeding through the stage of increased autonomy. It could be compared to healthy development which takes children through adolescence and early adulthood, then they move out on their own, establish their own families and come home for visits. In this case, the support group could be patient or mentor led and could have the option of the “parents” visiting on a regular or sporadic schedule. A support group fits with the empowerment model of GST and could be additional fortification for adult identity and support for the behavioral pattern-breaking phase of treatment. The group might eventually meet in a social context as friends who have done the BPD equivalent of going to college together and being in a sorority. This is a concept for future exploration. Our colleagues in Mainz (Reiss & Vogel, 2010) had patients who formed a support group with a good result reported by attendees. It has continued for two years after treatment and the group succeeded in being awarded a small grant to fund their activities.

In conclusion, the GST can be the place where a patient’s Vulnerable Child finds security and healing for early wounds, the internalized Punitive Parent

mode is banished, and the Angry and Impulsive Child is transformed into a strong and competent Healthy Adult that can support and comfort the child, meet needs, and embrace the Happy child part of them that makes life worth living. What we began with and called the “group from Hell” became one of the most powerful media for effectively treating BPD symptoms and improving the quality of life of this group of patients that we have found. In the process of leading 25 years of GST with patients with BPD we also learned a tremendous amount about ourselves, the power of therapy groups and the fundamental importance of human connection with our patients.

# The Patient Workbook Materials and How to Use Them

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This Chapter provides an overview of the course of Group Schema Therapy (GST) with the corresponding goals and interventions (Table 9.1), describes the main components of GST (Table 9.2) and a list of the Patient Workbook Materials which includes handouts, exercises, and homework forms that are organized by their treatment component and targeted mode (Table 9.3). The Patient Workbook materials are available for download on the Wiley website. A DVD set is also available that demonstrates the core interventions of GST (Zarbock, Rahn, Farrell & Shaw, 2011). This set includes a sample 90-minute group session using the GST model described in this manual led by Farrell and Shaw with a group of schema therapists playing patient-group members. The overview (Table 9.1) presents a rough guide by session and group of sessions to what we have found to be the general course or time-line of GST for Borderline Personality Disorder (BPD) as we have conducted it. We hope the reader does not use this rough guide like the skills training manuals of some other approaches to BPD treatment. We have tried to make it clear that ST is a treatment that is highly individualized to the patient or group of patients. Individual sessions weave back and forth in focus in response to the schema modes presented and the possibilities that develop for experiential work. Your group will be unique based upon the patients in it, their mode patterns, your co-therapist team, your personal style, and your own schema issues.

The specifics of individual sessions listed are rough guidelines of how our groups usually progress. You may choose a different order of sessions based upon your experience and your group. We list specifics to serve as

**Table 9.1** Overview table of Group Schema Therapy: rough schedule of primary mode focus, tasks and patient workbook materials

<i>Week</i>	<i>Main mode and glimpses</i>	<i>Content focus</i>	<i>Therapist task – be a Good Parent to all</i>	<i>Group task – be a supportive “family”</i>	<i>Related handouts, exercises and homework</i>
<b>Year one</b>					
Weeks 1 –6	DPM	Begin bonding	Connect via eye contact, warmth and genuineness, selective and strategic self-disclosure	Attend, do homework, follow ground rules, listen	Connecting and cohesiveness exercises
Overview	VCM	Safety			BPD Diagnosis
		Education about group therapy, ST model and BPD	Validate their presence and importance to the group		Information Handout and Homework form
			Communicate acceptance		BPD symptoms related to modes
			Provide safety		ST Information
					ST Model of BPD, etiology
					Safe Place image
					Emergency plan
<b>Week Details</b>					
1	DPM	Introductions	Validation	Validation	Group groundrules
	Maybe	Education about BPD	Genuineness	Respect	Safety Bubble exercise for group
	APM,	and ST theory	Acceptance	Bonding	
	BAM	Begin to establish commonalities	Positive attitude, hope		Homework 1 : BPD
			Connect and help the group make connections with each other		Symptom list

(Continued)

Table 9.1 (Continued)

Week	Main mode and glimpses	Content focus	Therapist task – be a Good Parent to all	Group task – be a supportive “family”	Related handouts, exercises and homework
2	DPM, some VCM	Begin with discussion of Homework 1: BPD Symptom list	Weave, identify commonalities and difference – both are accepted and validated	Share information	ST Model of BPD, etiology Mode information handouts Circle monitor with ID of safety issues Emergency plan
3 or 4	HCM ppm may flip in.	Add fun for balance	Make education information meaningful	Attend and contribute to discussions	“What’s My Mode” or other educational game or movie or TV clips that exemplify modes
4 or 3	HAM	Safety plan – preventing life-threatening behavior	Teach skills in group – this can be first group shared memory	Try various distress reducers introduced in group	Homework – Circle monitor Homework – “My experience of” each mode over next few weeks

5	All modes	Identify modes as they occur	Introduce this more flexible structure by mode, allay anxiety in group about less structure, weave to maintain connections that have formed and form new ones	Participate in identification of self and others Begin to verbalize needs to group – this can include the need to observe from “safe place” rather than active participation	Mode monitor summary forms Evaluate emergency plan and revise if needed
6	Review	Understanding ST model and applying it to oneself	Lead filling in Case conceptualization, weave group by identifying commonalities in experience and struggle	Attend and participate as able to	Safety or Mode Management Plan 1 has been completed

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Table 9.1 (Continued)

Week	Main mode and glimpses	Content focus	Therapist task – be a Good Parent to all	Group task – be a supportive “family”	Related handouts, exercises and homework
7–10	DPM May have glimpses of VCM, ACM, ICM	Get through or around DP mode Education, role of DP as survival strategy, how DP develops Point out Mode Management, as a healthier replacement for MCMs	Reach VC through eye contact, empathic connections, validation Continue bonding and work on group cohesiveness Cognitive work like pro and con list; “Court exercise”	Attempt to be open and step aside DP to allow VC to peek through	Feelings, Emotional Thawing handouts Pro and Con list for detaching Grounding and Safety Bubble exercise instructions Mode role-play with DPM, allow vicarious learning and have patients write about the experience of observing
8	DPM More glimpses of VCM	More education about normal childhood needs, good parenting and consequences of deficits in these areas	Empathic confrontation of APM Get through DPM with vicarious learning opportunities like role-plays, also emotional awareness exercises		Mode role-plays Juggling paper balls Magic tricks Games

9	VCM	Healing VCM Effects of childhood trauma Ways to identify and meet VCM needs	Meet VCM needs for compassion, comfort, nurturance, love, validation and acknowledgement of pain, shame Provide safety from PPM Reframe experiences to remove blame Meet fear with comfort and protection	Allow others to see VCM and respond to his/her needs, meet needs of VCM that are expressed, or with permission, those assumed	Exercises that provide comfort – use soothing objects Good Parent imagery, written cards, audiotapes Self-soothing handouts Construct Good Parent representation Letters to VCM Make VCM Treasure box for transitional objects and other keepsakes
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10	ACM, ICM Backlash of PPM	Discuss the function of ACM as innate reaction to unmet needs. ID current ACM needs Separate feeling angry and impulsive action	Allow venting Identify ACM needs, validate Contain anger safely Teach anger management and assertiveness	Make room for ACM venting, voice needs of VCM if present. Try going to the group “safe space” if VCM wants added protection	Venting Empathic confrontation Emotional release work, e.g., “fun with anger”, songs, physical release work Letters to ACM from HAM/therapist Monitor triggers of ACM
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Table 9.1 (Continued)

Week	Main mode and glimpses	Content focus	Therapist task – be a Good Parent to all	Group task – be a supportive “family”	Related handouts, exercises and homework
		How to identify triggers, use delay strategies to prevent impulsive action, beginning work on channeling anger into assertive and effective action			
11	ICM Backlash of PPM	ICM acts on unmet needs in a dysfunctional way ID impulsive actions – limit setting How to identify triggers, use delay strategies to prevent impulsive action	Set limits in ICM action – no harm or threat to others allowed	Observe the impulsive actions of peers	Monitor triggers of ICM

10–12	Review	Summarize work to date	Participate in identifying mode distribution	Summarize by using the first version of “Case conceptualization” form – pie chart of mode distribution in group
13	HCM PPM may flip in	HCM Fun, play, celebrations, explore interests	Coach, encourage, join in Help make these experiences emotionally salient, create group memories and remind of them in imagery	Play Fun exercises Opportunities for group play Play “assignments”, record experiences of play and celebration, e.g., zoo trip
14–16	PPM or DePM Flips to DPM	Separate PPM or DePM from self by identifying the source Experiential work to separate	Play “Good Parent” – fight PPM or challenge DePM as advocate for VCM Coach patient and group to do the same Ally group to fight PPM or DePM Banish PPM experientially	Information re healthy development, the needs of children and good parenting Letters to parents (not to send) Therapist and group confront PP in role-play or through psychodrama using effigies

(Continued)

Table 9.1 (Continued)

Week	Main mode and glimpses	Content focus	Therapist task – be a Good Parent to all	Group task – be a supportive “family”	Related handouts, exercises and homework
17–20	Any and all modes are possible	Mode change work Experiential and Cognitive	Good Parent by matching mode and need: e.g., comfort, validation, empathic confrontation, limit setting, etc. At times the child modes will now be adolescents and some parenting adjustments will need to be made.	Members have a more active role, sometimes as older sibs they may set limits or empathically confront DPM.	Use the imagery and role-play exercises in Chapter 7 for the VCM
20–30	HAM Flips briefly to any of the modes	Healthy Adult	Identify and observe HAM action Point out examples of accomplishments Cheerlead and praise Find ways to make salient and record positive	Continue to support peers in work and play	Record of accomplishments, notes from peers and therapist Collage of accomplishment Identity Bracelet

**In week 30 review and assessment, update individual case conceptualizations**

31–42	<p>Parent modes may come through More HAM. Less flipping and increased mode awareness</p> <p>Imagery mode change work Mode role-plays Both are determined by individual patient needs</p> <p>“Parents” give more trust, mastery opportunities to group Adolescent rebellions and challenges may occur – critical to stay with identifying underlying need, validation plus as needed limit setting</p>	<p>Members interact even more with each other as the peer group aspect of the therapy group develops</p> <p>This usually leads to more outside group interaction and at times they may bring issues from these interactions to the group to work on</p>	<p>Assignments that create evidence logs and summary antidote cards</p>
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36–45	<p>HAM, HCM</p> <p>Modes will depend upon individuals. Less flipping</p> <p>Identity clarification and stabilization – supported exploration of values, beliefs, career choice, partner choice begin here</p>	<p>Update case conceptualizations and make new mode distribution pie charts</p>
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Table 9.1 (Continued)

Week	Main mode and glimpses	Content focus	Therapist task – be a Good Parent to all	Group task – be a supportive “family”	Related handouts, exercises and homework
<b>Year two: months 1–6 First reduction in session frequency to weekly sessions</b>					
Session 1: Have a “re-commitment ceremony” for the group. Brainstorm the form this will take for your group with them. Review and celebrate the work of the first year. Make a plan with the group of the work that is needed that includes what each patient needs from the group. Discuss a plan for trauma healing work that patients will now have a strong foundation for.					
1–22	HAM, Some DeP activity VCM may react at first to change in session frequency	Autonomy PP has been banished, take on DePM in the process of developing their own healthy and reasonable standards Individual to group imagery work to heal VCM	Therapist leadership style shifts in response to more HAM presence in group members VCM needs to remain welcome and those needs met as well Call on HAM to support VCM	Peer group role strong – therapist supports and guides as needed to keep it healthy Patients need to focus on awareness of maladaptive coping modes being triggered and continuing to use the healthy care they have learned to give their VCM	Behavioral pattern breaking homework is now the focus Handouts and exercises on Identity

**Year two: months 7–9 Second reduction in session frequency to bi-weekly sessions**

23–34	HAM Any mode is possible, but much less flipping	Focus on using the self-understanding accomplished to set goals and improve quality of life	More shifting to a parent of adult children who is a consultant with a focus on empowerment	Group is very active with each other	More focus on living life with ability to be aware of maladaptive mode triggering Less focus on specific assignments and more on patients putting in place ways to continue their progress in strengthening their HAM and HCM
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**Year two: months 10–12 Final reduction in session frequency to monthly group sessions**

35–43	HAM Any mode is possible, but much less flipping	Graduation from the program Focus on the support needed for the next phase of life	Empowerment – stays sensitive to reactions to tapering in frequency of sessions	Group is very active with each other	Reviews of work done
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Table 9.1 (Continued)

Week	Main mode and glimpses	Content focus	Therapist task – be a Good Parent to all	Group task – be a supportive “family”	Related handouts, exercises and homework
44	HAM Any modes could peek in, but will be recog- nized by patients and choices made as to action	Celebration and saying goodbye to the therapy group with a possible new phase in either a support group or ongoing contact with peers and the availability of the therapists to be consulted as needed This is in the philosophy of ST			

Abbreviations: DPM = Detached Protector mode; APM = Angry Protector mode; BAM = Bully-Attack mode; CSM = Compliant Surrender mode; OCM = Overcompensating modes; VCM = Vulnerable Child mode; ACM = Angry Child mode; ICM = Impulsive/Undisciplined Child mode; HCM = Happy Child mode; PPM = Punitive Parent mode; DePM = Demanding Parent mode; HAM= Healthy Adult mode.

Table 9.2 Patient materials workbook – components of treatment, goals and abbreviations used in the text

<i>Treatment component</i>	<i>Goals</i>	<i>Handout/Homework</i>	<i>Pages</i>
Education	Understand BPD symptoms, identify theirs, understand how modes are involved, the etiology of BPD in ST terms, begin to learn Schema Therapy concepts and language	Info re: BPD/ symptom checklist Schema Therapy Childhood Needs	ED
Awareness	Understand the mode being focused on, their experience of it, the role it has played in their lives, and be able to identify when they are in it. Understand how it is related to BPD symptoms – in terms of current problems that are the target of treatment.	Experiential Focusing Exercise Mode Information Sheet My Experience of _____ Mode Circle Monitoring form Mode Monitoring form	AW
Cognitive Mode Change	Cognitive work on the mode Mode dialogues Pros and cons of mode Examine what maintains the mode – e.g., cognitive distortions Develop flashcards for each mode	Cognitive Antidotes form Pro & Con lists. Cognitive distortions by relevant Mode Flashcards	COG
Experiential mode change	Connection with secure attachment to therapists and the group. Safety work. Limited reparenting. Imagery, imagery change work Mode role plays, e.g., to banish the PP Find tangible representations to symbolize experiences – e.g., fleece to go with Good Parent Script, PPM effigies	Safety Bubble handout Safe Place Image Good Parent Script & Image Experiential Antidotes form Transitional objects Parent effigies	EXP

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**Table 9.2** (Continued)

<i>Treatment component</i>	<i>Goals</i>	<i>Handout/Homework</i>	<i>Pages</i>
Behavioral pattern breaking	Be able to identify when a mode is operating and the need underlying that mode. Develop healthy coping plans for each mode that include progressively healthier action to meet the underlying need. Practice using the MMP and refine it over time. Eventually MMPs become part of the Healthy Adult's skill repertoire.	Mode Management Plans Mode of week is main focus in sessions 1-12, and whatever other modes are present are brought into the work. In later sessions mode of focus will depend upon what is present in group.	BEH
Healthy Adult mode development	Develop and strengthen the Healthy Adult mode to be able to accomplish the specific ST goal for each mode, i.e., get through Coping modes, heal and protect VC, channel AC, limits for IC, banish PP and reform or banish DeP.	Healthy Adult worksheets Identity Handouts	HAM
Reference	This section includes various reference materials for therapists that are referred to in the GST Treatment Manual, e.g., Therapist Tips, Group Ground rules, how GST works.		REF

Materials that are specific to a particular mode are divided into the main mode sections. MCM = Maladaptive Coping modes; VCM= Vulnerable Child mode; ACM = Angry Child mode; ICM = Impulsive/undisciplined Child mode; PPM= Punitive Parent mode (Demanding Parent mode (DePM) is included with the PPM.

**Table 9.3** Index of patient workbook materials

<i>Component</i>	<i>Title</i>
<i>EDUCATION</i>	
ED ST-1	Schema Modes Defined
ED ST 2	Schema Therapy Goals
ED ST 3	The Course of GST for BPD
ED ST-4	Mode Origins Handout
ED ST 5	Core Childhood Needs
ED ST 6	Schema Mode- Unmet Childhood Needs – BPD Symptoms
ED ST 7	Your Experience of Modes form
ED ST 8	Understanding a current problem (BPD Symptom) in Schema Therapy Theory
ED ST 9	Clues that a Mode is operating
ED ST 10	Brain Biology of a Mode Activation
ED ST 11	Etiology of the Schema Therapy Model of BPD
ED BPD 1	Understanding the Diagnosis of BPD
ED BPD 2	BPD Symptom Worksheet
ED FEELINGS 1	Basic information about feelings
ED FEELINGS 2	The Color Game
ED FEELINGS 3	Emotional Thawing
<i>AWARENESS</i>	
AW 1-1	Circle Awareness Monitor Form
AW 1-2	Circle Info Mode Awareness Summary
AW 1-3	Circle Information: Your Experience of the Coping Modes
AW 2-1	Mode Awareness Monitor: Detached Protector Example
AW2-2	Mode Awareness Monitor Vulnerable Child Example
AW 2-3	Mode Awareness Monitor Angry/Impulsive Child Example
AW 2-4	Mode Awareness Monitor Punitive Parent Example
AW 2-5	Mode Awareness Monitor Blank Form
AW 3-1	Mode Awareness Monitor Summary VCM Example
AW 3-2	Mode Awareness Monitor Summary Blank
<i>COGNITIVE WORK</i>	
COG 1	Cognitive Antidotes summary by mode

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**Table 9.3** (*Continued*)

<i>Component</i>	<i>Title</i>
<i>EXPERIENTIAL</i>	
EXP 1	Level of Emotional Awareness Exercise
EXP 2	Good Parent Script
EXP 3	Good Parent Image
EXP 4	Soothing Images for the Vulnerable Child Mode
EXP 5	Rewriting Schema-related Childhood Memories
EXP 6	Imagery Change: Working with Positive Images
EXP 7	Positive Image Record
EXP 8	Schema Mode Roots worksheet
EXP 9	Bubble Safety Image
EXP 10	Safe Place Image
<i>BEHAVIOR PATTERN BREAKING</i>	
BEH 1-1	Safety/Emergency plan 1 Example
BEH 1-2	Safety/Emergency Plan blank
BEH 2-1	Mode Management Plan: Maladaptive Coping Modes Example
BEH 2-2	Mode Management Plan: Vulnerable Child Mode Example
BEH 2-3	Mode Management Plan: Angry/Impulsive Child Mode Example
BEH 2-4	Mode Management Plan: Punitive Parent Mode Example
BEH 2-5	Mode Management Plan: Blank
BEH 3-1	Steps in Mode Management: Vulnerable Child Mode
BEH 3-2	Steps in Mode Management: Punitive Parent Mode
BEH 3-3	Steps in Mode Management: Blank form
BEH 4-1	Mode Management Plan: Summary Example
BEH 4-3	Mode Management Plan: Summary Blank
BEH 5-1	Combination of Homework and Group Exercise Example
BEH 5-2	Combination of Homework and Group Exercise Blank
BEH 6	Assessment of Your Mode Management Plan
BEH ANT 1	Behavior: Antidotes Maladaptive Coping Modes

**Table 9.3** (Continued)

<i>Component</i>	<i>Title</i>
BEH ANT 2	Behavior: Antidotes Vulnerable Child Mode
BEH ANT 3	Behavior: Antidotes Punitive Parent Mode
BEH ANT 4	Antidote Use Record Form example
BEH ANT 5	Antidote Use Record Form blank
BEH ANT 6	Handout on Using Antidotes
BEH PROB 1	Problem Assessment & Mode Change Plan example
BEH PROB 2	Problem Assessment & Mode Change Plan blank
<b>ADDITIONAL PATIENT MATERIALS BY MODE</b>	
<i>COPING MODES</i>	
MCM 1	Information sheet: Coping Styles that don't work for Healthy Adults
MCM 2	Pros & Cons of Changing Old Coping Behavior example
MCM 3	Pros & Cons blank
MCM 4	Cognitive distortions that maintain unhealthy Coping Modes
MCM 5	Mode Awareness: Clues that a mode is operating
<i>VULNERABLE CHILD MODE</i>	
VCM 1	Information sheet: Vulnerable Child Mode
VCM 2	Meeting Vulnerable Child Mode Needs-Safety, Nurturance, Comfort
VCM 3	Transitional Objects for the Vulnerable Child Mode
VCM 4	Childhood Memories of Asking for Help
VCM 5	Identifying Childhood Memories Exercise
VCM 6	Handout: Why Schema mode roots are important
VCM 7 x	Vulnerable Child: "Big Plan" form
<i>ANGRY/IMPULSIVE CHILD MODES</i>	
ACM 1	Angry Child Information sheet
ACM 2	Cognitive Mode work: Handout, Homework : Flashcards
ACM 3	Angry Child Mode Discussion Topics: Healthy Attention
ACM 4	Homework: Channeling the ACM: Choice Points

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**Table 9.3** (*Continued*)

<i>Component</i>	<i>Title</i>
<i>PARENT MODES</i>	
PPM 1	Punitive Parent Information sheet
PPM 2	Pro & Con: Identify the impact of Parent modes example
PPM 3	Pro & Con List blank form
PPM 4	Cognitive Mode Work: Dysfunctional Parent Mode Messages worksheet
PPM 5	Handout: Antidotes to Punitive/Demanding Parent Mode
<i>HEALTHY ADULT MODE</i>	
	Year 2 has a large focus on this mode and repairing unstable identity.
HAM 1	Healthy Adult Construction
HAM 2	Assessing your Healthy Adult Mode Identity
HAM 3	Ways I can move into my Healthy Adult Mode
HAM 4	Schema Modes and Identity
HAM 5	Identity Information Circle
HAM 6	Identity Circle instructions
HAM 7	Awareness of the Healthy Adult Mode
HAM 8	Group Exercise: Developing Your Healthy Adult Mode
<i>REFERENCE</i>	
REF 1	GST Goals and Groundrules
REF 2	PRESS RELEASE about Schema Therapy
REF 3	STEPS IN THE MODE AWARENESS & MANAGEMENT PROCESS
REF 4	THERAPIST TIPS FOR GST
REF 5	SCHEMA CONCEPTUALIZATION FOR GST
REF 6	Co-therapist Connection-Centering Exercise
REF 7	Group THERAPIST TOOL KIT
REF 8	The Steps of Mode Change Work

markers on a road map for less experienced group schema therapists and therapists of different orientations. As you and your group progress with ST, more “detours” and “scenic routes” will be available to you. You will also inevitably revisit an earlier topic or homework. You will notice that

content moves somewhat slowly as we focus early on attachment, group cohesiveness, and establishing a safe environment.

The chart indicates which handouts go with which mode and phase of the work and corresponds to the content and tables of Chapters 5 to 8. We have listed the range of weeks (e.g., 1–6) in which the modes are initially covered and suggestions about pace by dividing material further into separate sessions (i.e., separate sessions 1, 2, 3, etc.). The specific session numbers refer to the approximate sessions in which an education topic or mode is a *main emphasis*. The divisions also suggest what we see as *the upper limit of the amount of material (handouts, homework and exercises) to cover in a session*. After the initial focus, we shift to the presenting modes of patients and emphasize the aspect of their presentation or experience that relates to the content focus of the session.

For example, if the focus of the session is on the Vulnerable Child mode, the content material has been presented and one patient is detached and shut down, the therapist can identify the mode and inquire about the possible relationship between the content topic and a coping mode occurring. If the patient is agreeable, therapist and group can move into experiential or cognitive work to get through their Detached Protector mode to reach their Vulnerable Child. In another session, patients might all be in the Vulnerable Child mode and the identified topic is Angry Child mode. The therapist could lead the group in a Safe Place image as a way to protect the Vulnerable Child, and then complete the Angry Child material, but we would be inclined to shift the content focus to the Vulnerable Child, taking advantage of the opportunity presented by patients being in the mode that we most want to access and heal. The Angry Child mode could be the focus of a future session. One can also combine these strategies by weaving back and forth between the two related modes, even demonstrating experientially how they are related (i.e., patient flips quickly from Vulnerable Child mode to the “protection” of Detached Protector mode or release of the Angry Child mode because needs are not being met).

This flexibility to match modes and your individual group is an integral practice of ST. ST does not dictate as “best for all” any particular set of skills or order of the therapeutic work. Patients react positively to this individualized approach and we think it is one of the factors that account for the higher retention rate in ST compared to other approaches to BPD. The patient’s experience of having his/her unique combination of needs, personal strengths, characteristics, and traumas seen and considered in defining what is of help is in itself part of the experiential healing of GST.

Patients tend to object to being fitted into “one size fits all” plans or specific skill sets as this response to them can feel like invalidation, although this is not the intention of skill-focused treatment. The examples given here illustrate the balance between the flexibility of session task and strategic work to help patients change dysfunctional life patterns and get their core needs met in an adaptive manner outside of therapy.

# Combining Individual and Group Schema Therapy

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This chapter briefly summarizes what we know about the results of combining individual Schema Therapy (ST) and Group Schema Therapy (GST) from outcome studies and clinical practice and provides suggestions about how to coordinate this combination. Both individual ST and GST have growing empirical validation for their effectiveness for Borderline Personality Disorder (BPD) patients (summarized in Chapter 12). The one randomized control trial (RCT) of GST (Farrell et al., 2009) evaluated the addition of a weekly GST session to ongoing weekly individual therapy that was *not* ST. The treatment-as-usual condition, individual therapy, had no significant effect on BPD symptoms or global functioning, while the GST added condition had large positive treatment effects. Individual ST for BPD has been demonstrated in an RCT and an implementation study to have strong significant effects on BPD symptoms and quality of life (Giesen-Bloo et al., 2006; Nadort et al., 2009). We have pilot studies that suggest positive treatment effects for the combination of individual ST with GST in inpatient settings (Reiss et al., submitted) and outpatient settings (Dickhaut 2010). A large multi-site study of the combination has been described in Chapter 1 with the formats for the two combinations presented in Chapter 5. In clinical practice, three of the authors have conducted this model of combined individual ST and GST in inpatient and outpatient settings for a combined total of 20 years. The other authors are experienced individual schema therapists.

The model for combined individual ST and GST is one in which the two modalities are coordinated, with therapists sharing all information and



meeting regularly in clinical and/or peer supervision. Both modalities have the same goals and use the same ST and GST models. Different ratios of group and individual sessions are possible and are likely to have different benefits and coordination issues.

## **Treatment Protocols**

The protocol for individual ST follows Arntz & van Genderen (2009) and Young et al. (2003). The protocol used for GST is this treatment manual. Reiss, Jacob & Farrell (2011) describe a case example of combining the modalities in an inpatient program.

## **Therapists**

In the GST for BPD model, two therapists conduct the group sessions. Those two therapists could also act as individual therapists, ideally dividing the patients equally between them. This is the approach used for the inpatient ST programs. In that case there were four group therapists who divided groups and patients. In the outpatient setting there was more variability. In our original study, individual therapists (not schema therapists) and group therapists were different people and the two treatments operated independently of each other. In our outpatient setting and in the GST trial there is a great deal of variability in terms of whether a patient's individual therapist is also a group therapist. We have been the group and individual therapists for entire groups. The combination used often depends on the practical realities of clinical settings. We have found that all of these combinations can work beneficially. It will take additional research to decide whether one is optimal.

## **Training**

In the multi-site GST trial, all therapists have at least standard certification in ST and have attended at least six days of GST training combined with ongoing supervision that began weekly with a tapering schedule after six months to biweekly and then monthly in Year 2 of treatment.

## **Individual Sessions**

### *Coordinating Information*

We make it clear to the patients that all information is shared between the individual and group therapists. However, information shared in individual sessions will only be shared with other patients in the group with specific permission from the patient. On the other hand, information from the group sessions conveyed to the individual therapist is shared with the patient in their individual sessions. Sometimes the group therapists will be aware of information about a patient not known to the group that it would be helpful to share. The way we approach this is to ask the patient in the group session if we may share a particular piece of information (also described in Chapter 4). We frequently say to patients, “Would you be willing to tell the group about the situation you experienced that relates to this issue?” Sometimes the patient has no idea what we are referring to. In that case, we go further and say, “Is it OK if I briefly mention the situation you were in last week in which mode flipping (or whatever the group’s topic is) occurred?” We reveal just enough for the patient to consent or not. They usually consent. In general, anything that would leave someone feeling embarrassed or too exposed should only be shared by the patient when they feel ready. This practice is also explained to the patient at the beginning of therapy.

The two modalities share a treatment plan and a case conceptualization. Individual sessions can be used for a more in-depth case conceptualization. Individual therapists can help a patient understand how group topics and work apply to him/her. The individual therapist may be able to add information to group therapists’ awareness of a patient’s reaction to group and understanding of the group process. The individual therapist can go over homework from group in more detail and help with understanding and meaningful use of the homework. This can help the patient stay engaged and prevent drop-outs. The individual therapist will have a rough schedule of group topics and access to session notes and vice versa. It is helpful for the therapists to regularly acknowledge the roles of both modalities directly. For example, in group they could ask if the patients have anything that has come up in individual sessions that they would like to share with the group or think is important for the group to know. The individual therapist can regularly ask the patient how he/she experienced the group session. Individual problems the patient has in the group that they don’t know how to handle can be an individual session topic. The patient’s ability to share and

connect in the group and, over time, to share painful information such as abuse can also be discussed. A patient missing a group or individual session without a good reason is always discussed.

### **Ways to Use Combined Group–Individual ST**

- The two modalities are likely to pull for different modes, providing a more complete picture of the patient's functioning.
- Patients with avoidant features may bond more quickly in individual sessions.
- Patients with narcissistic or antisocial features and overcompensating coping styles may handle empathic confrontation more positively in individual sessions without an audience.
- GST does not focus on a lot of individual sharing of information. Instead "stories are told" in pieces as the information pertains to the group session. Patients with the need to share details to feel understood or to "tell their story" of abuse experiences in more detail can do so first in individual sessions and then work in the group to "rewrite the ending" in imagery. Patients may need more time to work on traumatic memories than is available in the group. Sometimes they are too ashamed of what happened to share it in the group. It is strongly recommended that trauma work be postponed until a strong enough attachment has been formed with the Vulnerable Child mode to allow for mode change work to be done in the context of a new and safe relationship. If this is not done, it can be felt as re-traumatization. It may not be possible to fully postpone this work if the abreactions are strong and frequent, but it is best to try to save depth work until later. Alternatively, if the patient has suffered traumas and is not discussing them even later in treatment, it will be important to address the avoidance involved. This is something that can be monitored in both the individual and group work.
- Material often comes up in group that can be worked with further in individual sessions. In addition to trauma, awareness of particular coping styles, interpersonal issues with other group members, and issues with the group therapists are among the potential topics for discussion. It may be easier to begin to deal with sensitive personal issues in individual sessions. The individual therapist can make decisions in the best interest of the individual patient to either encourage the patient to take an issue to the group or vice versa.

- Patients usually have had more experience, thus more comfort, with individual therapy. The individual therapist can make suggestions about how they can work on particular issues or needs in the group. Role-playing of communicating a need to the group can also take place. Sometimes patients feel more comfortable bringing up issues with individual therapy in group as they may fear potential loss of the individual therapist. In our first RCT we frequently worked with the patients in group on how to communicate their needs to their individual (non-ST) therapists. They could role-play ways to communicate intense distress rather than taking an action like self-injury.
- The information flow between therapists ensures that all are aware of critical events and information that may only be shared or observed in one of the modalities. Awareness of current life events helps in understanding surprising mode flips or coping modes in group.
- Crises can be dealt with more efficiently at times in individual sessions and help can be offered that is specific to a given patient (e.g., difficulties involving housing, or income).
- Group can be a more powerful setting for experiential work, in particular mode role-plays.

### **Potential Coordination Problems**

- Patient has difficulty managing more than one “parent”, thus idealizes one and vilifies the other; strongly preferring one therapist or modality and focusing work only there.
- Jealousy or competition between peers who are individual patients of the same therapist; difficulties sharing.
- Feelings of being treated differently or unfairly by one of the therapists.

### **Joint Supervision and Peer Supervision**

Both group and individual therapists should attend these meetings regularly. Peer supervision or team meetings in inpatient settings should match patient sessions in frequency.

The goals of peer supervision are:

- Exchange of information about the patients.
- Planning of the next sessions from the treatment manual.

- Discuss any therapist schemas that are activated in treatment and how to work with them.
- Support and advice for each other about the treatment.

Possible problems for discussion in peer supervision include:

- Inadequate valuing of both modalities.
- Competition between individual and group therapists.
- Favoring one's individual patients. Wanting to be the patient's favorite therapist.
- An individual therapist identifies too much with his/her patient making him/her unable to discuss problems between two group members like Good Parents in a Healthy Adult mode with respect for others point of view. (It is important to view all behaviors as expressions of modes and to figure out which therapeutic intervention is most appropriate.)
- Conflicting views of patients' goals and needs.
- Individual therapists disagree with the assessment or intervention used by the group therapist(s) or the reverse. For example, assessing modes differently, thus giving conflicting limited reparenting responses – one is validating and supportive seeing the Vulnerable Child and the other is limit setting seeing the Impulsive Child.
- As in normal families, the “children” sometimes try to play one parent against the other to reach their goal. It is important that all therapists are aware of this process and try to view disagreements as opportunities to find a solution for complicated situations and not start quarreling as rivals.
- Group therapists focus on the individual process of their patients and miss the group process. (This will hopefully be caught by the co-therapist.)

We have found that all of the potential problems of combining individual ST and group ST can be managed in coordination meetings of all the therapists. Clinically, we observe that the two modalities work well together and augment each other. The multi-site GST trial will shed some light on questions such as what ratio of the two is optimal in terms of treatment and cost effectiveness. A well-coordinated combination of individual ST and group ST where all therapists respect each other, convey confidence in all therapists to the patients, and view both modalities as important contributors to a patient's treatment can provide patients with the “best of both worlds.”

# Meeting Core Emotional Needs in Group Schema Therapy Through Limited Reparenting

Poul Perris and George Lockwood

Limited reparenting in Group Schema Therapy (GST) involves actively trying to fulfill the client's frustrated core emotional needs within the therapeutic relationships provided by the co-therapist "parents," group member "siblings," and the "healthy family" experience GST provides. To set the tone and guide the way, it is helpful for GST therapists to have a clear understanding of these needs and how they relate to the development of healthy schemas and modes. We define a core emotional need as the affective neurobiological state an individual is in when s/he is missing a socio-cultural nutriment required for psychological growth and health. An Early Adaptive Schema (EAS) represents the healthy counterpart to an Early Maladaptive Schema (EMS). We define it as a broad, pervasive theme or pattern, comprised of memories, emotions, cognitions, and neurobiological reactions regarding oneself and one's relationship with others, developed during childhood or adolescence, elaborated throughout one's lifetime and *leading to healthy functioning and adaptive behavioral dispositions*. EAS are formed when a child/adolescent grows up in a family and socio-cultural context that responds adequately to core emotional needs. They are internal representations of these positive patterns that take the form of flexible, rather than rigid, templates. These templates lead to traits and states that promote successful interpersonal and independent functioning and ongoing fulfillment of core emotional needs without harm to others. The early versions of these templates are positive yet relatively crude and simple. For example, a child with a Trust EAS will be globally trusting. As a child's cognitive capacities develop and needs continue to be adequately responded to, EAS are continually elaborated and

refined, leading to later adaptive schemas characterized by integrated and fluid states and flexible, balanced, nuanced, and selective behavior. The child with a Trust EAS becomes an adult who is able to make nuanced decisions about how much to trust a given individual in a given situation and thus is able to balance a tendency to be trusting with a reasonable degree of caution. While these later refinements and extensions are important, we hypothesize that the affective core is rooted in the early templates. This adaptive behavior is seen as the result of the Healthy Adult mode integrating and modulating the information and energy flowing from the full range of adaptive schemas and states. We see these executive functions of the Healthy Adult mode developing throughout the lifespan beginning in childhood. This process, from the initial kernel of an EAS to the development of the full range of EAS and associated adaptive behavioral dispositions orchestrated by a healthy adult mode, are the fruits of limited reparenting within GST.

The Core Emotional Needs Model (CNM) can be used as a guide for limited reparenting in which the EAS and the adaptive behavioral disposition make the goals of reparenting clearer and more explicit and the list of interpersonal nutriments act as the goals for therapeutic interventions. The specific words used to label an EAS are important in capturing what we believe to be the essence of this dimension of healthy functioning, while the adaptive behavioral disposition makes clear what we believe this essence looks like in everyday life. The interpersonal nutriments help to engage the interactions that are believed to lead to these healthy patterns. (These labels and corresponding definitions and descriptions were arrived at after extensive discussion with Jeffrey Young.)

In the following section we will refer to adaptive schemas (AS) rather than EAS since, when working with adults, healing usually starts with a blending of early and later forms. We have limited our discussion here to the AS most relevant for patients with BPD and have not included Physical Safety/Resilience and Emotional Openness. Each AS is followed by a description of what is needed within relationships, examples of reparenting strategies that the therapist can use within the group setting, and examples of self-help strategies to assign to clients so that they can work independently on promoting their AS and Healthy Adult mode.

While we have included three newer schemas (Approval-Seeking/Recognition-Seeking, Negativity/Pessimism, and Punitiveness) in the discussion because of their relevance for BPD, it is important to note that they have not yet been examined through repeated factor analytic investigations and thus do not yet have a strong empirical base. For this reason we have not yet included them in the CNM and they do not appear in Table 11.1.

Table 11.1 Early maladaptive schemas, interpersonal nutriment, early adaptive schemas and adaptive behavioral dispositions<sup>1</sup>

<i>Early maladaptive schema</i>	<i>Interpersonal nutriment that meet core emotional needs</i> <i>A need for:</i>	<i>Early adaptive schema</i>	<i>Adaptive behavioral disposition (adult form)</i> <i>The ability to:</i>
Abandonment/Instability	a stable and predictable emotional attachment figure.	Stable attachment	find and maintain relationships with others who will be there when you need them in a predictable way, and will not leave.
Mistrust/Abuse	honesty, trustworthiness, loyalty, and the absence of abuse.	Trust	trust others intentions and give them the benefit of the doubt and to balance this with a reasonable degree of caution.
Emotional deprivation	warmth and affection, empathy, protection, guidance, and mutual sharing of personal experience.	Emotional fulfillment/ Intimacy	form intimate relationships with significant others that include disclosing private needs, feelings, and thoughts and sharing love and affection.
Emotional inhibition	a significant other who can be playful and spontaneous and who invites the same in you and others and encourages you to express emotions and talk about feelings.	Emotional Spontaneity	express and discuss emotions freely; behave and respond spontaneously and without inhibition when appropriate

(Continued)



**Table 11.1** (Continued)

<i>Interpersonal nurtiments that meet core emotional needs</i>		<i>Adaptive behavioral disposition (adult form)</i>	
<i>Early maladaptive schema</i>	<i>A need for:</i>	<i>Early adaptive schema</i>	<i>The ability to:</i>
Defectiveness/Shame	unconditional acceptance of, and	Self-Acceptance/Pride	be self-accepting and compassionate towards oneself and genuine and transparent to others.
	love for, one's private and public self along with regular praise and the absence of ongoing criticism or rejection. Encouragement to share areas of self-doubt and not keep them secret from others.		
Social isolation/ Alienation	inclusion in and acceptance by a	Social inclusion/ affinity with others	seek out and connect with social groups that share the same interests and values and the ability to find similarities and common ground with others.
	community with shared interests, and values.		
Failure	support and guidance in developing mastery and competence in chosen areas of achievement (educational, vocational, and recreational).	Mastery/Success	accomplish meaningful educational, work, and recreational goals.

Vulnerability to harm or illness	a reassuring significant other who balances reasonable concern for harm and illness with a sense of manageability of these risks and models taking appropriate action without undue worry or overprotection.	Physical safety/ Resilience	have a realistic sense of safety and physical resilience and to enter into situations freely if they do not involve physical danger and respond calmly to minor physical symptoms. Be both confident and proactive regarding risks involving harm and illness.
Dependence/ Incompetence	challenge, support, and guidance in learning to handle day-to-day decisions, tasks, and problems on one's own, without excessive help from others.	Competence/ Self-reliance	handle everyday tasks and decisions without an over-reliance on others, along with the ability to seek out help when needed (being "independent but well connected").
Enmeshment/ Undeveloped self	a significant other who promotes and accepts one having a separate identity and direction in life, and who respects ones personal boundaries.	Healthy boundaries/ Developed self	have one's own life direction, convictions, beliefs, interests, and feelings and have appropriate boundaries between oneself and others.
Subjugation	freedom to express needs, feelings, and opinions in the context of significant relationships without fear of punishment or rejection.	Assertiveness/ Self-expression	assert and express needs, feelings, and desires in relationships even when these differ from, or are in conflict with, significant others and, at the same time, remain open to compromise.

(Continued)

**Table 11.1** (Continued)

<i>Early maladaptive schema</i>	<i>Interpersonal nurtiments that meet core emotional needs A need for:</i>	<i>Early adaptive schema</i>	<i>Adaptive behavioral disposition (adult form) The ability to:</i>
Self-sacrifice	balance in the importance of each person's needs. Guilt is not used to control expression and consideration of one's needs.	Mutuality/Self-care	treat one's needs as no less important than anyone else's and find the healthy balance between getting one's needs met and helping others.
Unrelenting standards/ Hypercriticalness	guidance in developing appropriate (not too low, rigid, or extreme) standards and ideals and In balancing performance goals with getting other needs met (health, intimacy, relaxation) along with a forgiving attitude toward mistakes or imperfections.	Realistic standards/ Acceptance of imperfections	flexibly adapt standards to one's abilities and circumstances and to be forgiving of one's failures and imperfections.

Entitlement/Grandiosity	guidance and empathic limit setting to learn the consequences for others of your actions and to empathize with other people's perspectives, rights, and needs. Not made to feel superior to others and limits placed on unrealistic demands.	Reciprocity/Equality	take the perspective of others, show consideration and respect for their needs and feelings, and to experience oneself and others as having equal value.
Insufficient self-control/ Self-discipline	guidance and empathic firmness in forgoing short-term pleasure and comfort in order to complete day-to-day routines, responsibilities, and meet longer term goals. Limits placed on expressing emotions that are out of control, inappropriate, or impulsive.	Self-control/ Self-discipline	forgo short term gratification and immediate impulses for the sake of ones responsibilities to one's self and others and one's long term goals.

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## Social Belonging

This AS involves having a global sense of belonging and connectedness to the world and to other people. For example, having friends that include you in their plans and activities and with whom you feel you have a lot in common.

**Core need:** Inclusion in and acceptance by a community with shared interests and values.

**Meeting the Need:** Encourage each group member to share experiences about growing up, good and bad, including the therapists (within appropriate limits). Talk about values and norms from home, at school, and among friends. Discuss hobbies and interests, favorite TV shows as a kid, comic books they used to read, music they enjoy listening to, etc. Link their emotional suffering to core human needs and clarify that, at the deepest level, we all experience the same emotions when these needs are not met; that underneath it all, we are more alike than we are different. Support clients seeking out and connecting with individuals and groups outside sessions that share the same interests and values. Use exercises that involve finding similarities and common ground, including that between clients and therapists.

## Stable Attachment

This schema involves the sense of having an emotionally stable and dependable base. This comes from an ongoing experience of having an important person who is fully committed to you and who will be by your side whatever happens.

**Core need:** A stable and predictable attachment figure.

**Meeting the Need:** Be available to clients between sessions as possible. Tell each client the ways you can always be there for them. Check in on them occasionally between sessions (e.g., with an email) to show that you think of them outside scheduled sessions. Be as predictable and stable in your mood as possible, while also showing frustrations (within healthy limits). Stand up for your clients outside sessions, if needed. Work actively as a team to provide the group with a sense of stability so that there is a feeling that the group as a whole will always be there for each member. Encourage

members to seek out significant others outside of group sessions to form secure attachments with.

## **Emotional Fulfillment**

This schema involves feeling loved, understood, guided, and protected by someone you love. It includes sharing deeply and treasuring time together.

**Core need:** Warmth and affection, empathy, protection, guidance, and mutual sharing of personal experience.

**Meeting the Need:** Be emotionally present, alert, playful, and curious during sessions. Use a warm soothing tone of voice with the Vulnerable Child and playfulness to reach the Happy Child. Warm, playful, or caring eye contact is an especially powerful way to establish connection. This can be done by seeing the delightful little boy or girl in the clients' adult faces. Develop an attuned connection by understanding and linking hurtful experiences in the here and now to his/her EMS and early childhood experiences. Offer direct and explicit nurturance and care when patients are feeling upset. This may include physical touch (e.g., a hug) if a patient has expressed comfort with this and you know that it is experienced in a nurturing rather than sexual way. Use transitional objects such as pictures or minor personal items. Point out personal traits that you like. Encourage the formation of intimate relationships outside sessions and the practice of disclosing needs, feelings, and thoughts. Help clients express love and affection toward their Vulnerable Child and share what they appreciate about group members. Support clients to share warmth, affection, and understanding and protecting one another.

## **Basic Trust**

This schema involves feeling that the people you depend on are honest and trustworthy and that they act with your best interest at heart.

**Core need:** Honesty, trustworthiness, loyalty, and the absence of abuse.

**Meeting the Need:** Be transparent as a therapist. This involves being open and collaborative (e.g., providing your clients with a clear rationale when introducing a new topic or intervention) and appropriate self-disclosure. Disclose, within realistic limits, frustrations or negative feelings you might

have framed in a Healthy Adult way, for example, “Yes Amber, one side of me is frustrated with you for continuing to interrupt Eric when he’s venting his anger, on the other side I know how upsetting anger is for you.” Acknowledge mistakes (e.g., “Yes, I did get into my head too much that time and wasn’t as focused on just being with you and your feelings.”) rather than trying to save face. Encourage clients to take healthy risks in asking for help. Help clients learn to discern when and with whom trust is warranted and when and with whom it is not. Teach them to differentiate between others intentions and the overt impact of their behavior.

### Success

This schema involves having the sense of being successful; having accomplished meaningful and important things.

**Core needs:** Support and guidance in developing competence, success, and mastery in chosen areas of achievement (school, work, and leisure time).

**Meeting the Need:** Conduct exercises and give homework assignments that clients find interesting and challenging, but manageable. Praise successful achievements and sincere efforts. For example: “It’s amazing how much you’ve improved your confrontational skills in the relationship with your mother since you started in this group. I’m really proud of how hard you have worked at this and how far you have come.” Praise group members’ helpful input to others. Encourage and support what clients feel passionate about or find intrinsically rewarding. Praise active and ongoing participation as much as results.

### Self-Acceptance/Lovability

This schema involves feeling lovable and liking yourself as a person and includes accepting your flaws, viewing yourself as worthy of attention and respect, and feeling comfortable with your physical appearance.

**Core need:** Unconditional acceptance of, and love for, one’s private and public self along with regular praise and the absence of ongoing criticism or rejection.

**Meeting the Need:** Provide a group atmosphere characterized by openness and unconditional acceptance. Normalize many kinds of thoughts,

feelings and behaviors. Discuss the difference between fantasies, urges, feelings, and desires and acting on them. The latter involves limits so that no one is hurt while the former does not. An open and accepting group atmosphere helps group members be more open to looking at their perceived flaws and weaknesses. Help clients view “shameful” issues from the vantage point of acceptance, understanding, and compassion. In imagery have them picture themselves experiencing the shame provoking situation and their Healthy Adult mode being there (with therapist and the other group members if needed) to provide understanding and compassion. Provide regular praise and help clients to feel comfortable about feeling proud of themselves and their efforts and with your being proud of them.

### **Healthy Boundaries/Developed Self**

This schema involves having a clear sense of a separate self. It includes knowing who you are, your values, and what you stand for independent of others. It also involves having clear and realistic boundaries.

**Core need:** A significant other who promotes and accepts one having a separate identity, a unique direction in life, and personal boundaries.

**Meeting the Need:** Watch for a client copying you as it could express their undeveloped self. Promote clients’ separate sense of self by asking for personal opinions and preferences. For example, use imagery to create a private room with a “do not enter” sign on it, furnished and decorated just as they like. Reinforce this with a drawing or symbol and add it to their images of comfort or safety. Help clients develop and pursue a personal vision in various life areas (e.g., partner/intimate relationships, school/work, leisure time, friends, and family of origin.). Assign Chapter 17 in *reinventing your life* (Young & Klosko, 1993).

### **Self-Reliance/Competence**

This schema involves feeling capable of taking care of yourself independently and that you can rely on yourself in everyday functioning.

**Core need:** Challenge, support and guidance in learning how to handle everyday decisions, tasks, and problems on one’s own, without excessive help from others.



**Meeting the Need:** Encourage clients to face and take on challenges you judge them to be ready for in an empathetic way. Help the client develop an effective approach to the task (e.g., provide guidance in things like time management, organization, or prioritization if needed) and offer constructive feedback and praise.

Help clients take on graduated assignments. Assess what they do on their own and what others do for them or responsibilities that they neglect.

### **Assertiveness and Self-Expression**

This schema involves feeling free to state your personal opinion, needs, and feelings in close relationships.

**Core need:** Freedom to express needs, feelings, and opinions in the context of significant relationships without fear of punishment or rejection.

**Meeting the Need:** Educate your clients about feelings and how core emotional needs are linked to feelings (e.g., how feelings of sadness communicate the need for comfort, or shame communicates the need for acceptance and inclusion). Encourage clients to assert and express needs and feelings within the group even when they are different from the others, while remaining open to input and compromise.

### **Empathic Consideration/Respect for Others**

This schema involves the sense that all people are equally important and valuing fairness over having to have things your way.

**Core need:** Guidance and empathic limit setting regarding the consequences to others of your actions.

**Meeting the Need:** Set appropriate limits when clients violate the needs of others or make unreasonable demands, making sure this is done in a fair and balanced way. Encourage clients to take the perspective of others, show consideration and respect for their needs and feelings, and to experience oneself and others as having equal value.

## **Healthy Self-Control/Self-Discipline**

This schema involves having a reasonable degree of impulse control over expressing feelings and pursuing desires. It also involves the ability to maintain a functional degree of structure, focus, and organization and an ability to balance short- and long-term interests.

**Core need:** Guidance and empathic firmness in forgoing short-term pleasure and comfort in order to complete day-to-day routines, and meet responsibilities and longer term goals. Limits placed on expressing emotions that are out of control, inappropriate, or impulsive.

**Meeting the Need:** If clients act impulsively and express strong anger or other negative emotions within the group, helpful reparenting involves empathic limit setting that allows venting, clarifies links to early childhood experiences, reality-tests the present situation, discloses effects on you and the group, and identifies the underlying need and how to express it in an effective manner that considers other's needs. Role-play the new adaptive behavior with group feedback. Be a good role model for structure and discipline by keeping track of session time. Encourage clients to forgo short-term gratification for the sake of responsibilities to self and others and long-term goals. Provide assignments for practice and problem solve difficulties clients have with them.

## **Optimism/Hopefulness**

This schema involves having a sense that things usually turn out well in the end, that the future is full of possibilities, and a focus on what is going well rather than badly, bounded by a realistic sense of risks and problems.

**Core need:** A significant other who role models dealing with difficulties in a realistic, constructive, and optimistic way.

**Meeting the Need:** Optimistically focus on concrete issues that a client feels stuck on and problem solve in the group. Use exercises that identify clients' strengths and abilities to strengthen a sense of hope and optimism that things can be solved.

## Realistic Standards and Expectations

This schema involves a sense of accepting “good enough” when working on goals and having balanced and realistic expectations of self and others.

**Core need:** Guidance in developing appropriate standards and ideals and in balancing performance goals with getting other needs met (e.g., health, intimacy, relaxation).

**Meeting the Need:** Model realistic standards. Admit in-session mistakes openly and disclose minor mistakes from outside sessions. Give yourself compassion and forgiveness.

Encourage clients to flexibly adapt standards to their abilities and circumstances and to be forgiving of their failures and imperfections.

## Healthy Self-Interest/Self-Care

This schema involves caring for your own well-being as much as you care for the well-being of others.

**Core need:** A significant other who balances the importance of each person’s needs.

**Meeting the Need:** Provide clients with attention and nurturance, and allow clients to offer care and nurturance towards you (within realistic limits). Model adaptive self-care. Encourage your clients to balance meeting their needs and helping others.

## General Considerations

As mentioned earlier, the adult form of the EAS is something that evolves over time. It is important to have realistic expectations and to point out and reinforce the growth. Meeting needs at first emphasizes the therapist serving as the healthy adult and directly meeting the client’s needs. The client gradually internalizes these behaviors and attitudes and, along with the help of the educational and skill training aspects of limited reparenting, develop the capacity to meet many of their own needs and to find significant others to depend on. The limited reparenting of core emotional needs can be a complex task for the therapist. For example, as much as we need unconditional love and free will when growing up, we also need to be exposed

to realistic limits and social norms. Responding to needs such as connection is often an easier and more straightforward task than responding to needs such as realistic limits. A schema therapist providing limited reparenting is often striking a balance between these two types of competing needs. In GST it is advisable for co-therapists to take turns meeting needs that feel good and meeting needs for adequate limits and structure. This balance allows clients to experience both therapists as valuing the full range of needs and minimizes the risk of one being perceived as the “good cop” and the other as the “bad cop.”

# A Systematic Review of Schema Therapy For BPD

Arnoud Arntz

The present authors are aware of six relevant studies that assessed the effects of outpatient Schema Therapy (ST) for Borderline Personality Disorder (BPD), and one manuscript that presents the results of three pilot studies on inpatient ST. We excluded single case reports, as being methodologically weak.

## Outpatient ST

Four of the six relevant studies were randomized clinical trials (RCTs), one a consecutive case series, and one an open trial. All studies employed structured diagnostic interviews for diagnosing BPD (five studies used the SCID-2, one the DIB-R (Farrell et al., 2009), so we are fairly confident that patients met the DSM-IV classification of BPD.

We first discuss the six studies, then present the results of two meta-analyses on these studies. Meta-analysis is a statistical technique to combine the results of different studies, so that a general conclusion can be drawn.

The six studies are:

1. Giesen-Bloo et al. (2006) and van Asselt et al. (2008). This was a multi-center RCT comparing individual ST to individual Transference Focused Therapy (TFP), a psychodynamic treatment, in BPD outpatients. Three years of treatment were studied, though treatment could be completed within the 3-year period, or could be continued. Primary outcome was BPD severity, assessed with the Borderline Personality Disorder Severity

Index (BPDSI). Over 3 years, ST had better treatment retention than TFP: significantly less ST patients than TFP patients dropped out of treatment (27% vs. 50%). ST was superior to TFP on primary outcome (45.5% vs. 23.8% met the statistically derived recovery criterion on the BPDSI at 3 years; at 4-year follow-up this was: 52.3% vs. 28.6%; moreover, 66% of the ST patients reported a reliable reduction on the BPDSI, vs. 43% of the TFP patients). ST was also superior to TFP on secondary outcome measures, including measures of personality pathology, self-esteem, and quality of life. For the meta-analysis, we used the reduction on the BPDSI as primary outcome. The van Asselt et al. (2008) study reports the cost-effectiveness analysis of this study. ST was dominant to TFP: less costly and more effective on the primary outcome. As to the quality of life adjusted years of life during the 3 years of treatment, no major differences between the two treatments were detected. The general conclusion is that ST was superior to a high-quality alternative psychotherapy, TFP, in terms of treatment retention, recovery from BPD, reduction of BPD manifestations, indicators of personality and general psychopathology, quality of life, and cost-effectiveness.

2. Zorn et al. (2007; 2008). This was an RCT comparing group formats of a cognitive therapy (CT) containing ST elements, to social skills training for outpatients with various personality disorders. Both conditions consisted of 30 sessions of 100-minutes delivered to 7–10 patients. Only 20 of the total 93 patients had BPD. The social skills training had considerably higher drop-out rate (34.8%) than the CT–ST combination (6.4%). Many outcome measures were reported and no primary outcome measure was indicated. We therefore averaged effect sizes over the outcome instruments. The relevance of the study for the present overview is doubtful, given the small proportion of BPD patients, the lack of a BPD-severity measure, and the fact that a full-ST package was not delivered. For the sake of completeness we included the study in this overview.
3. Farrell et al. (2009). This RCT investigated the effects of group ST (GST) offered to BPD-patients already in a “treatment as usual” (TAU), as an adjunct to their treatment. The study compared GST added to TAU, to TAU alone, in a sample of 32 BPD outpatients. The GST consisted of 30 sessions of 90 minutes, delivered over 8 months in groups of 8 patients. None of the patients from the ST-group dropped out compared to 4 of the 16 TAU-only patients (0% vs. 25% drop-out). Main outcome was borderline severity assessed with the BSI. Strong effects of a limited dose

of GST were found, and almost no effects for TAU. After treatment, 15 of the 16 (94%) ST-patients no longer met BPD diagnosis as assessed with the DIB-R criteria, while 11 out of 12 (92%) of control group still met BPD diagnosis. The results should be interpreted in view of the fact that the treatment developers delivered the treatment, and that participants were recruited from those able to maintain 6 months of treatment before the study began. Future studies will ascertain to what degree the effects are generalizable to other centers and patient populations.

4. Nadort et al. (2009). This multicenter RCT compared an individual ST condition with and without crisis telephone support by the therapist in the context of an implementation trial. Main outcome was BPD severity assessed with the BPDSI. No differences between the two ST conditions were found. For the present review we combined results from the two conditions at the end of study (Nadort et al., 2009) and used them for the within-ST meta-analyses, as a between conditions comparison does not make sense with both conditions being ST. Treatment was 2 sessions per week for year one and decreased in frequency over the remaining 2 years. At 1.5 years, a 21% drop-out rate was found. The results are comparable to those of the Giesen-Bloo et al. (2006) trial, demonstrating that ST can be successfully implemented in usual health care with structured training and regular supervision.
5. Nordahl & Nysaeter (2005). A consecutive case series study with 6 BPD outpatients. Individual ST was delivered once per week between 1.5 and 3 years, depending on the patient's needs. Various outcome instruments were used; we used the average pre-post within group effect size for the within-ST meta-analyses. There was no drop-out, and at 12 months follow-up it is reported that 50% of the patients no longer met the BPD diagnosis.
6. Dickhaut & Arntz (2011). An open trial of the Maastricht research group into the effectiveness of group-ST combined with individual ST for BPD outpatients. During 2 years, 2 sessions per week were offered: one group sessions (90 minutes), and one individual ST session; 18 months results were available, but not the 2 year results. Primary outcome was BPD severity assessed with the BPDSI.

### *Meta-analysis*

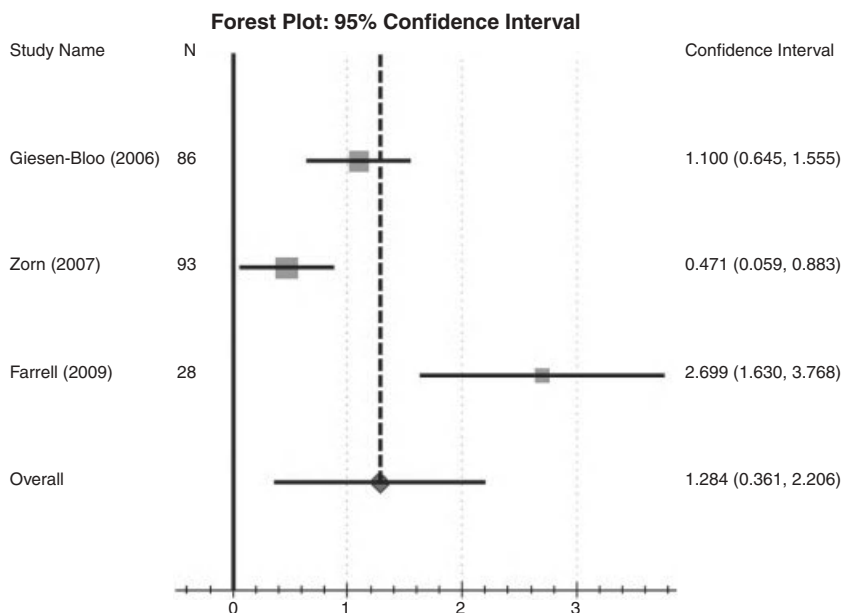
We based the meta-analyses on intent to treat results. If a BPD severity index was available, that was taken as outcome. If it was not available, results

expressed as effect sizes were averaged across outcome measures (Nordahl & Nysaeter, 2005; Zorn et al., 2007). The relevance of the Zorn et al. study was viewed as limited given that only 21.5% of the participants had BPD, and the experimental treatment was not a full ST package. Given the small number of RCTs of ST vs. another treatment, the study was used in the between condition meta-analysis. If anything, it contributed to a rather conservative overall effect size estimate, as it had a relatively small effect size. For the within ST, we left it out of the analyses as data from five studies were available. We meta-analyzed Cohen's  $d$ , calculated from the change in dependent variable from pre- to post-test, with the standard deviation (SD) of the change score:  $d = \text{mean change} / \text{SD}_{\text{mean change}}$ . This effect size expresses the effects of treatment as the average effect the treatment has divided by the dispersion of the effect over the participants. For the so-called controlled effect sizes, the comparison of effects of ST with those of other treatments, Cohen's  $d$  was calculated from the statistical tests of the studies, and can be understood as the difference between the two treatments in the mean change from pre- to post-test, divided by the pooled standard deviation of the change in the two conditions:  $d = (\text{mean change}_{\text{ST}} - \text{mean change}_{\text{Control}}) / \text{pooled SD}_{\text{mean change}}$ . Positive Cohen's  $d$  denotes improvement. For the comparison of ST to control treatments, a positive  $d$  denotes superiority of ST over control conditions. Values of  $d \geq 0.8$  are considered to represent large effects, whereas a  $d = 0.5$  is considered to represent a medium effect, and  $d \leq 0.2$  a small effect.

*Meta-analysis: ST vs. control treatments* Three RCTs compared ST (or a variant, Zorn et al., 2007) to a control treatment. One to TFP (Giesen-Bloo et al., 2006), one to social skills training (Zorn et al., 2007), and one to TAU (Farrell et al., 2009). Figure 12.1 shows a forest plot of the between condition effect sizes (Hedges  $g$ ). Differences between treatments probably relate to: differences between control treatments with TAU as the least effective (within  $ES \approx 0$ ), TFP as relatively the most effective (within  $ES > 1$ ); and the fact that the Zorn et al. (2007) study did not include a full ST package. The results of the meta-analysis indicate that despite the differences between the studies (notably, between the control groups), there is a clear evidence that ST is more effective than other treatments, with a large mean effect size of 1.28.

*Meta analysis: within ST changes* We derived within ST effect sizes from five studies that included only BPD outpatients (pre-post effect sizes, Cohen's  $d$ ). Figure 12.2 shows the Forest plot.





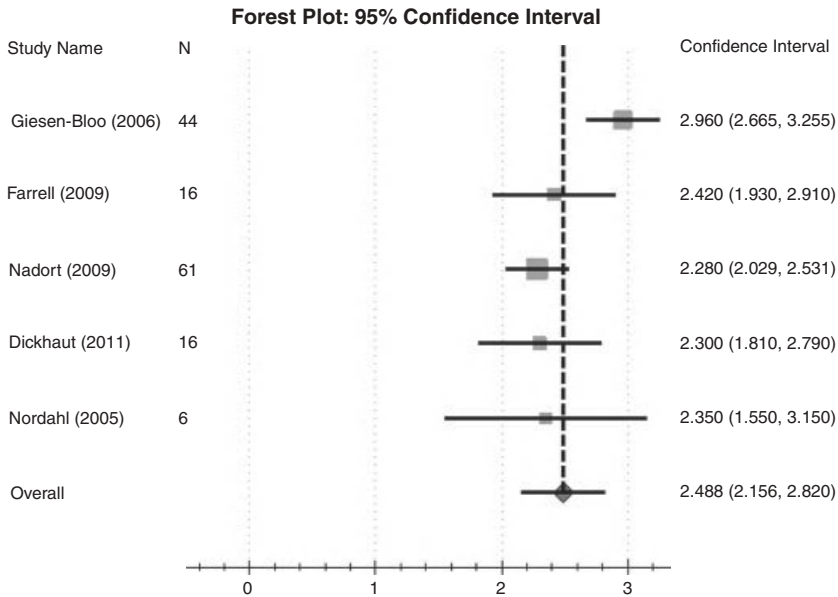
**Figure 12.1** Forest plot of between condition effect sizes (Hedges  $g$ ) of ST vs. control treatment of three RCTs. Positive values denote superior effects of ST. Random effects model. Analyzed with Meta-Analyst (Beta 3.13)

The within-condition effect sizes are quite similar, indicating that ST has quite stable effects. Moreover, the average effect size is very large,  $d = 2.49$ . Differences between RCTs in between condition effect sizes (Figure 12.1) seem therefore more attributable to differences in the comparison groups. Note that the two studies involving GST (Farrell et al., 2009; Dickhaut et al., 2011) had much shorter treatment times (up to 18 months) than the studies investigating individual ST (up to 3 years).

## Inpatient ST

One manuscript reports the results of three pilot studies of inpatient ST (Reiss et al., in press).

The first study was done by Farrell and coworkers (Reiss et al., in press) among 41 BPD inpatients in Indianapolis, USA. Diagnoses were confirmed by a clinical interview conducted by an experienced clinician and a



**Figure 12.2** Forest plot of within condition effect sizes (Cohen's *d*) of five ST trials. Positive values denote improvement. Random effect model. Analyzed with Meta-Analyst (Beta 3.13)

score of at least 8 on the Diagnostic Interview for BPD-Revised (Zanarini, Gunderson, Frankenburg & Chauncey, 1990). Post-treatment assessment was done at discharge, which was variable, on average after 4.5 months. Patients were treated by two specialist therapists in GST. Individual ST was done by trained therapists. Very strong effects are reported, but no follow-up assessment after discharge was done, so it is unclear to what degree the effects were maintained. Although no formal follow-up measures were possible, the incidence of rehospitalization, self-injurious behaviors (SIB) requiring medical care and suicide attempts recorded for 28 of the 42 patients (67%) for the period 1 year after treatment was obtained. Of that group, 86% (24/28) had no hospitalizations, 6% had one brief (less than 10 days), and an additional 8% had two brief hospitalizations. In terms of SIB – 100% reported SIB that required medical care in the 30 days before treatment and at 1 year follow-up only 18% had SIB of that severity. For suicide attempts, 100% had a recorded attempt in the year before treatment and at one year follow up only 14% had had a recorded suicide attempt in

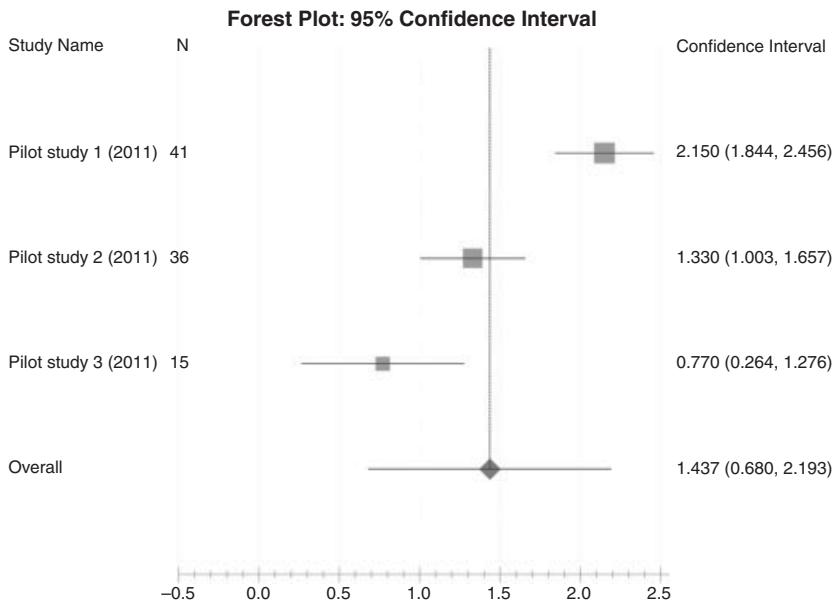
the year post-treatment. It may be that these figures are better in the group that could be followed due to their remaining in stable care compared to those lost to follow-up. However, it still indicates very positive improvement considering the severity of their pre-treatment symptoms.

The second pilot study was also done by Farrell and coworkers (Reiss et al., in press). This later cohort consisted of 36 BPD patients. Diagnoses were confirmed by clinical interview and the Questionnaire of the Clinical Interview for DSM-IV Personality Disorders (SCID-II; First, Spitzer, Gibbon & Williams, 1996). Post-treatment assessment was done after 12 weeks of inpatient treatment. Individual ST was delivered by trained therapists and GST was the main treatment modality. But GST was led by only one therapist, due to financial limitations of the hospital. Somewhat less strong effects are reported in this cohort, probably related to the change in therapist number. No follow-up assessment after discharge was done, so it is unclear to what degree the effects were maintained.

The third study was done by Reiss & Vogel (2010) in Mainz, Germany. Participants were 15 female patients with a diagnosis of BPD, as assessed with the SCID-II (First et al., 1996). Again GST was the main treatment modality, but therapists were trained in individual ST with no specialized GST training. Patients were assessed and discharged at the end of the 10-week program. This study had a 3-month follow-up. Less strong effects are reported than in the American pilots, possibly related to the difference in treatment program and the fact that therapists had no specialized training or experience in GST. The follow-up shows some (not significant) deterioration from post-treatment.

### *Meta-analysis: within treatment effects of inpatient-ST*

All three pilot studies used a BPD-severity instrument to assess changes. These were used for the meta-analysis. Figure 12.3 presents the Cohen's  $d$  effect sizes of the pre-test to post-test changes, all highly significant improvements. In contrast to the outpatient studies, improvements are highly variable over the three pilot studies. Nevertheless, the average effect size is high,  $d = 1.44$ . Note that the studies were uncontrolled: so we do not know what part of the effect of inpatient-ST can be attributed to ST, and what part to other factors, such as time, being hospitalized in a controlled environment, attention, etc. Also note that only one of these pilots had formal follow-up (3 months) and one had the report of outpatient treatment providers on BPD symptoms (1 year) for 67% of the patients.



**Figure 12.3** Forest plot of within condition effect sizes (Cohen's  $d$ ) of three inpatient ST pilot studies. Positive values denote improvement. Random effects model. Analyzed with Meta-Analyst (Beta 3.13)

## Conclusion

Studies so far indicate that outpatient ST is a highly effective and safe treatment for BPD. The pre- and post-effect sizes are remarkably similar across studies, indicating that results can be replicated. Between condition effect sizes show more variability, but that is probably associated with the different control conditions that varied from an ineffective TAU (Farrell et al., 2009) to a quite effective psychodynamic specialized treatment (TFP; Giesen-Bloo et al., 2006). The two studies involving GST for BPD attain similar effects as individual ST in less time, suggesting that they speed up recovery processes. The promising results of GST need further study in a multicenter trial. Such a study is underway by an international workgroup with 14 sites and  $N = 448$ .

The evidence for inpatient ST is more limited. The pilot studies are uncontrolled – thus it is not clear for what part the improvements that are reported in the patients are attributable to ST. A problem in evaluating

inpatient treatments is that being taken care of 24 hours per day in a controlled environment might in itself lead to reduction of BPD manifestations. Second, only one study reported formal follow-up results. Given the length of these inpatient treatments, and the fact patients returned to life outside the sheltered environment of the hospitals, it is important to document to what degree effects are sustained. The results of the German inpatient ST treatment suggest that some relapse can occur. The treatment provider reports of re-hospitalization, SIB, and suicide attempts for the US study indicate maintenance of improvement in the group engaged in active outpatient follow-up treatment. It seems therefore wise to develop outpatient ST programs to maintain and deepen the effects of inpatient ST. It would also be beneficial to evaluate ST programs in intermediate levels of care such as day hospitals or intensive outpatient treatments. Such evaluations have begun by an international work-group. A group format could be an effective and efficient modality for outpatient follow-up at a range of levels of care.

# Conclusions and Future Directions for Group Schema Therapy

Neele Reiss, Joan Farrell, Arnoud Arntz and  
Jeffrey Young

## Using GST to Treat Other Personality Disorders

The promising results of Group Schema Therapy (GST) for Borderline Personality Disorders (BPD) raise the question of whether GST would also be an effective treatment for other personality disorders (PD). Research to evaluate this question is in the pilot stage, as is most psychotherapy outcome research for PDs (McMain & Pos, 2007; Verheul & Herbrink, 2007). We can speculate about the effectiveness of this GST model for other PDs based upon their empirical association with modes. Lobbestael et al. (2008) and Bamelis et al. (in press) found a good deal of mode overlap with the various PDs, particularly with BPD in which most modes are present. In addition, as Lobbestael et al. (2008) demonstrated, all of the mode categories are present in BPD (Child, Maladaptive Coping, Dysfunctional Parent and Healthy modes), so GST has developed and adapted interventions for all basic modes.

### *Cluster-C PDs*

Similarities in the pattern of mode association and the frequency of childhood abuse (Lobbestael, Arntz & Bernstein, 2010) in Avoidant (APD), Dependent (DPD) and BPD suggest that this GST model could be a good fit there. GST opportunities for vicarious learning are very effective in getting through the Coping modes which are prominent in these PDs. The added

safety, support, and allowance to go at your own pace of the GST model for BPD should be a good fit for APD. Our clinical observations from hundreds of hours of group treatment of patients with co-morbid APD support these speculations. An example is “Karen” in Chapter 7 with comorbid-APD who responded well to vicarious learning. She felt unable at first to play any mode-role herself, but her Vulnerable Child mode was impacted emotionally by watching us play her modes. This response is typical of patients with APD in GST.

The core needs of childhood (Young et al., 2003) apply to everyone. Bamelis et al. (in press) give an example of a man with OCPD who reacts with an overcompensating coping style when he has schemas of defectiveness, abandonment, emotional deprivation and mistrust-abuse triggered. In this example, treatment focused on his Abandoned (Vulnerable) Child mode. A patient with BPD in the same situation might have responded with a different Coping mode, but the same Vulnerable Child mode would be present with an underlying need related to attachment.

### *Cluster-B PDs*

Another obvious candidate to try GST with is the forensic PD population, given the prominence of cluster-B PDs. However, patients with prominent narcissistic and anti-social features are usually contraindicated for inclusion in BPD groups, as their overcompensating coping styles can threaten the safety needed by BPD or APD patients. Of course, Bully-Attack mode behavior is as frequent in BPD (Bamelis et al., in press) and we have found it to respond to GST interventions of empathic confrontation and firm limits. The Overcompensator of ASPD and NPD might require even firmer enforcement by the therapists of the group ground-rules that prohibit attacks of any kind on peers. As forensic patients would be more accustomed to the levels of hostility and denigration they display, this could be less of a problem with an all-forensic group. Bamelis et al. (2011) suggest that PDs with strong overcompensator modes, which function to keep up the appearance that the opposite of the schema is true, may be reluctant or unable to report the more Vulnerable Child and Parent modes that the ST model hypothesizes that they also have. Nonetheless these modes are observed in clinical work with the PD population.

The vicarious learning component of GST, which is so effective with APD, could also be effective in reaching the Vulnerable Child mode of these PDs. Bernstein et al. (2007) in describing their work with forensic patients, state

that the ASPD strongly resembles BPD in that the Abandoned and Abused Child, Angry Child, Punitive Parent and Detached Protector are central modes in both. Males with a primary BPD presentation are frequently found in forensic settings rather than psychiatric hospitals. We would expect GST to be particularly helpful to this neglected segment of the BPD population. They assert that the basic ST treatment approach remains the same with minor adjustments for the therapeutic needs of forensic patients. They see the main difference as the need for therapists to be aware of, and skillful in working with, the modes prevalent among forensic patients. They report that a trial of the effectiveness of their adjusted ST model is underway. Bernstein's group also started to develop a group ST version for forensic PDs. Beckley & Gordon (2010) also report that a pilot of their group approach for forensic patients is underway. As far as we know, neither employs the GST model presented here, and no comparison of models is possible as neither group has yet published. Farrell & Shaw (2011) suggest that the major adaptations of BPD GST that would be necessary for this population includes: firm enforcement of ground rules about respect for and absence of aggression toward peers, and awareness of possible therapist negative countertransference. They base this on their experience leading non-ST group therapy for APD patients, dealing with the APD features of patients in BPD GST groups and supervising a pilot of forensic GST.

### **GST shares the applicability of ST for all PDs**

ST was designed to treat all PDs. In all ST, limited reparenting matches the mode present and the underlying needs, independent of the disorder. GST, like the ST model that it is consistent with, focuses interventions on the modes that are present in a patient. This should make it adaptable to any patient or PD. As described earlier, the possible disruptive effects of some modes (e.g., Bully-Attack) may be best handled in homogeneous groups as was done with the BPD GST model. On the other hand, the heterogeneity and comorbidities of the BPD population means that we have treated all PDs in the various trials and pilots of this GST model. The early focus on group cohesiveness via universality and shared childhood experiences and Vulnerable Child mode allows for heterogeneity with modes and could accommodate other PDs. We have not yet had the sample size to evaluate comorbid PDs as a predictor of outcome, however the large effect sizes found indicate overall successful treatment.



BPD patients were not seen as good candidates for any group therapy before our RCT and the results for Dialectical Behavior Therapy (DBT) skills groups. It was necessary for us to adjust the group environment to their needs. This kind of adjustment is part of the core of all ST and we speculate that it is also a reason for the effectiveness we are demonstrating for BPD patients in individual or group ST. There should be no more problem treating other PDs in GST than there is for treating BPD. The advantages of the group modality for ST that we present in Chapter 2 would apply for other PDs. The education component of the group could easily be adjusted based upon the disorders involved.

### **The Role of the Healthy Adult**

Attention would be paid to the strength of the Healthy Adult mode of patients to determine the balance between the therapists acting as Good Parents and the role of the group as peer or socializing force. BPD patients have a weak Healthy Adult mode when treatment begins and need strong parents in the therapists. Other PDs may have more of a Healthy Adult mode to join the therapists earlier to parent the Vulnerable Child mode, but we are somewhat skeptical of there being large differences in severe PDs.

We see the PDs as having more similarities than differences. In terms of ST goals:

- All have a Vulnerable Child mode who did not have his/her needs met in childhood. The subtypes – abused, abandoned, lonely, or dependent – may require minor adjustments in reparenting style. For example, the dependent child may have an excessive parent connection and need to have their autonomy supported in small steps earlier than the BPD patient who has not experienced attachment. Any patient in the Vulnerable Child mode needs a Good Parent – the question is how much this role is played by the therapists, the group, or the Healthy Adult of the patient.
- Different default coping styles are presented, but all are protective and dysfunctional and need to be replaced by healthier coping. It may be more difficult or take longer to break through the Coping modes by which antisocial patients protect their Vulnerable Child mode. Coping styles may vary, but are still survival based. Different coping styles require

different therapist responses and possibly group ground rules regarding aggression and acceptance of differences. Patients with any Overcompensator need firm limit setting and empathic confrontation. Compliant Surrenderer needs a different response than Detached Protector.

- Parent modes may be Punitive or Demanding, the former requires banishing and the latter moderating.
- All have Healthy Adult modes that need to be strengthened and Happy Child modes to be evoked and encouraged.

### **Intensive GST for severe BPD**

Another important potential use of GST is treatment for the severe end of the BPD continuum found in inpatient and day therapy settings. The evaluation of clinical and cost effectiveness of specialized treatment for inpatients with BPD is a neglected research area. Studies have focused on outpatient treatment (Zanarini, 2009), where the severe end of the BPD continuum is either excluded or not referred due to their need for a higher level of care. Patients referred for inpatient treatment have the most severe symptoms, have not responded to a variety of outpatient treatments, and cannot be safely maintained outside of the control of a hospital. Hospitalization is necessary when a patient's life is threatened; however, specialized inpatient treatment is not widely available, compelling clinicians to use general psychiatric inpatient treatment of unknown effectiveness. General inpatient psychiatric care, usually designed for severe Axis I patients, may not meet the needs of BPD patients. It has even been suggested that traditional inpatient care of more than a few days has the potential to trigger counter-therapeutic regression (Gunderson & Links, 2008).

Despite such findings, Lieb et al. (2004) reported that 75% of individuals with BPD will be hospitalized in the course of their treatment. This figure is even higher in Germany, reported as 80% with an annual average of 65 days (Bohus et al., 2004). Despite this frequent use, there is little data evaluating inpatient treatment programs or even reports of what treatment is used in these settings. The studies of inpatient combined individual and group ST ( $N = 91$ ) provide a starting point for the evaluation of specialized BPD treatment other than DBT (Reiss et al., submitted). They provide preliminary evidence that inpatient ST where GST is the main treatment modality can significantly reduce symptoms of severe BPD and global severity of psychopathology.

Another important use of intensive GST to investigate is in the less restrictive and less expensive setting of Day therapy or Intensive outpatient (Evening therapy in the US). A day hospital setting could be an effective treatment alternative for many patients with BPD. As argued in the previous section on application of GST to other PDs, specialized inpatient and day therapy programs for mixed PD GST or other homogeneous PD groups would also be important to investigate.

Future studies of intensive GST need to use a control group and randomization and control the length of treatment. The Reiss et al. (submitted) findings add further evidence that inpatient programs for patients with severe BPD can do more than keep them safe with external control at a high cost. An important question these studies raise is whether GST in an intensive model would have similar effects delivered in day therapy or intensive outpatient. If it does, then these treatments would be an important option to be made widely available at a more affordable price for public health care settings.

## Conclusion

Many of the issues raised in this chapter need to be investigated empirically to provide more grounded speculations and testable hypotheses regarding the effectiveness of GST with non-BPD patients. For example, the idea that the needed emotional learning and schema change of particular developmental stages may be best facilitated by a particular modality. Patients with a stronger and more accessible Healthy Adult mode may not need a “family” group, rather a peer group. Two therapists are important for the all BPD group, with a high level of emotional need and abandonment and emotional deprivation schemas, but a single therapist may be adequate for other patient groups and two therapists will not be practical in many settings. We think that a second therapist would be needed in forensic settings, as in BPD, to maintain connection and also the ground rules. The frequency of sessions needed, the optimal combination of group and individual sessions, predictors of treatment outcomes, patient retention, cost-effectiveness and cost-utility, requirements of therapist training, and the preferences of the most important stakeholders, patients and therapists, all need additional evaluation. Much of the recommended research to further test GST is already underway. The large ( $N = 448$ ) multi-site international trial of group and individual ST for BPD, pilots of GST in Day treatment for BPD and

mixed PDs in the Netherlands, inpatient GST for mixed PDs in Switzerland and for forensic patients in Australia. The GST model has been enthusiastically received by ST with its potential for more effective PD treatment. The large effect sizes for GST in the Farrell et al. (2009) study are compelling and there are significant economic and service delivery reasons as well to expand development and testing of the group modality. Just as individual ST is being used for many different patients and problems and has growing empirical validation, we anticipate similar expansion and validation for GST in the future.

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# Index

*Note:* Page numbers with italicized *f*'s and *t*'s refer to figures and tables, respectively.

Initials refer to the patient materials indexed on page 312.

- Accepting differences, 47–51
- Adaptive behavioral dispositions, 271–85, 273–7*t*
- Adaptive parenting, 271–85
- Adherence measures, 5
- Adolescence, 232–4
- Aggression, 32, 52–3, 109, 210
- Anger, playing with, 209–11
- Angry Child mode, 1, 125, 204–13
  - Cognitive interventions, 206–7
  - Experiential interventions, 207–12
  - Behavioral pattern breaking, 212–13
- Angry Protector mode, 53–6, 61–3, 76, 130, 145, 155–7, 163, 209–11, 226
- Anticipatory socialization, 87–91
- Antisocial features (*see also* Bully-Attack mode), 50, 79, 268, 298
- Apology, 70
- Assessment, 72, 81, 88, 146, 234–5, 253, 260–61 (BEH 6, PROB 1, 2)
- Attendance, 45, 83–4
- Attention, healthy need, 30, 197–8
- Autonomy, Stage Three, 225–43
- Avoidant coping style, 13, 38
- Avoidant personality disorder, features, 31, 38–40, 55, 67–8, 74–5, 77, 192, 268
- Awareness
  - Emotional awareness, 1–2, 127–30
  - LEA EXERCISE, 127–9, 127 (EXP 1)
  - Mode awareness interventions, 11, 15–16, 91–2, 132 (AW 1-2, 1-3)
- Belonging (*see also* Bonding), 25
- Bonding, 45, 106–8
- Borderline personality disorder
  - DSM-IV-R criteria, 14
  - Education about, 110–11 (ED BPD-1, 2)
  - Etiology in ST terms, 110

- Borderline personality disorder
  - (*Continued*)
  - Modes and BPD, 11*t*
  - Role of Schema modes, 119–21*t*
- Bully-Attack mode, 13, 29, 32, 56–8, 66, 145–6, 209, 211, 256
- Chair work (*see also* mode role-plays), 153–6, 216
- Circle monitor form, 72, 92, (AW 1-1, 1-2, 1-3), 130–31, 131*f* (AW 1-1)
- Clues (of a mode occurring), 149 (ED ST-9)
- Cluster B personality disorders, 296–7
- Cluster C personality disorders, 295–6
- Cognitive antidotes, 93 (COG 1)
- Cognitive interventions, 33, 92
  - Cognitive distortions, 93 (MCM 4), 215
  - Dichotomous thinking (*see also* Pro and Con list), 2, 33, 161
  - Restructuring, Reattribution, 16
- Cohesiveness, 24–5, 45, 48–9, 68, 85, 89, 99, 106–8, 110, 112–17, 202–3
- Combining individual and group ST, 265–70
- Compliant Surrender coping style, 13, 65, 71, 124, 146
- Confidentiality, 54–6, 58
- Conflict in group, 20, 40, 43–4, 49, 70–71, 87, 205, 211, 241
- Coping modes (*see* Maladaptive Coping modes), 13–14, 123–4, 145–63
- Corrective emotional experiences, 196–8
- Co-therapist team, 40–44, 69
  - Signals, 41
  - Connections exercise, 78 (REF 6)
- Course of GST, 244–56*t*
- Crisis intervention (*see also* emergencies), 71
- Defense mechanisms, 13
- Demanding Parent, 10, 15, 28, 32–3, 61, 64, 68, 213–14, 223–5, 227–8, 238
- Detached protector, 13–14, 28–9, 31–2, 46, 62, 67, 73–4, 110, 122, 128–9, 138–9, 146–8, 151–3, 156–7, 160–63, 188, 192, 196, 234, 238, 240, 263
- Dissociation, 11, 13, 15, 52, 73–4, 116
- Dysfunctional Parent modes (*see also* Punitive and Demanding Parent modes), 10, 14, 17, 68, 73, 112, 118, 207, 214, 228, 230
- Early adaptive schemas, 271–85, 273–7*t*
- Early maladaptive schemas, 271–85, 273–7*t*
- Education component GST, 91, 108
- Education GST, 109–10
- Education ST, 112 (ED ST 1-11)
- Effigies, 42, 215–16, 222
- Emergencies
- Emergency plan, 80, 94 (BEH 1-1, 1-2), 140
- Emotional dysregulation, 13, 63
- Empathic confrontation, 3, 15, 17, 38, 54–6, 84, 146, 155, 211–12, 268, 296, 299
- Emptiness, 14, 24, 28, 89, 206, 228
- EMS (*see* schemas)
- Exclusion criteria, 79
- Experiential interventions (*see also* according to mode), 31–3, 93–4 (EXP 1-9)
- Eye-contact, warm gaze, 46
- Family of origin, Recapitulation, 29
- Feelings
  - Color Game, 129 (ED F2)
- Fight, flight freeze, 13
- Flashbacks, 73
- Flashcards, 93 (ACM2)

- Flexibility, 5
- Formats for group schema therapy, 83*t*
- Goals, 2, 4, 8, 16, 18–19, 24, 69, 78, 103–5, 114, 141–2, 204, 226, 236
- Good Parent, 32, 39, 48, 59, 65, 75, 100, 115, 155, 166, 170–71, 173–4, 179–88, 191, 195, 198, 207, 216, 218–20, 222–3, 225, 227, 232, 241
  - Messages, script, 96–7, 178–9
- Graduation from group, 241
- Ground rules for group, 45, 52–3, 90
- Group family, 23, 25, 30, 37–9, 45–51, 173, 218–20
- Group size, 80
- Group space, 84–5
- Happy Child mode, 14–15, 144, 159, 201–5, 225
- Healthy adult, 14, 224–43, 288–9, 298
  - Cognitive interventions, 234–6
  - Experiential interventions, 236
- Homework, 68–9, 98–103, 109, 111–13, 122–3, 126, 161, 165
- Hope, 9, 14, 24, 26–7, 88, 110, 122, 144, 230, 241
- Identity, 14, 26, 228–31
- Identity bracelet exercise, 49, 237–9
- Imagery (*see also* Safety), 171–95
  - To access VCM, 174–5
  - Good Parent, 96–7, 178–9
  - “Ice Cream Cone” Image, 177–8
  - “Little Child on street”, 133
  - Rescripting, 97, 101, 170–74, 178–95
- Inclusion criteria, 79
- Individual patient focus (in group sessions), 16, 31, 40–42, 67, 191–2
- Individual schema therapy, 20, 27, 29, 36, 40, 46, 59, 68, 192, 209
  - Coordinating with GST, 265–71
- Inpatient GST, 3, 299–300
- Insecure attachment, 13, 26
- Intensive GST, 3, 299–300
- Interpersonal learning, 27, 94–5, 239–41
- Interpersonal nutriments, 271–85, 273–7*t*
- ISST (International Society Schema Therapy), 4, 88
- Kinesthetic awareness, 2, 127, 158
- Length of treatment, 79, 82, 300
- Limit setting, 3, 15, 17, 52, 57, 63, 84, 146, 211
- Limited reparenting, 2, 16–17, 23, 28–30, 34–5, 37–78, 91, 182–95, 230
  - Broadened to a family, 53–77
- Maladaptive Coping modes, 13–14, 123–4, 145–63
  - Antidotes, 164*t*
  - Awareness, 147–50
  - Behavioral pattern breaking, 153–6, 160–61
  - Cognitive interventions, 151 (MCM 2, MCM 3), 153 (MCM 4)
  - Experiential interventions, 156
  - Integration, 161–3
  - Mode role-plays, 162
- Management issues, 53, 70–77, 85
- Mentors, 63, 81, 200, 242
- Mistrust/abuse schema, 26, 45, 59, 88–9, 100, 103, 127, 197
- Mode Change work
  - Steps of, 144–5
- Mode conceptualization, 140–41*f*
- Mode flipping, 14–15, 63, 73, 132, 138, 209
  - Stress-related psychosis
- Modeling, 17, 24, 45, 65, 77, 94, 174, 203

- Mode Management Plans, 66, 72, 94  
(BEH 2, 3, 4), 200 (BEH 3-1)
- Mode Monitoring, 92 (AW 2-1, 2-2,  
2-3, 2-4, 2-5, 3-1, 3-2), 147,  
200
- Narcissistic features, 39, 75–7, 79, 268,  
296
- Needs, 10, 15–17, 50–53  
Conflicting needs, 59, 64–5  
List of childhood needs, 62, 113  
Therapist meeting needs (*see also*  
limited reparenting), 37–49  
Unmet childhood needs, 50, 60–63*t*
- Nonverbal therapist behavior, 40–41,  
46–8, 97, 155, 183
- Opportunity work – “seize the  
experiential moment, 31, 35, 65,  
103–5, 198
- Other diagnostic groups, 295–9,  
foreword
- Overcompensation coping style, 13, 27,  
75, 117, 123, 146, 152, 268  
Patient involvement in group, 67–8
- Patient stories, 26
- Patient support groups, 242
- Patient workbook materials, 87,  
244–64  
Index, 259–64
- Peer group, group siblings (*see also*  
sibling rivalry), 27, 30
- Peer supervision, 269–70
- Physical Grounding exercise, 158–9
- Pilot trials, 3, 22, 24, 82, 265, 295,  
297
- Play (*see also* Happy Child mode), 15,  
133, 144, 159, 201–4, 228, 233
- Post-treatment surveys, 25
- Pro and Con, 93 (MCM 2, 3)
- Punishment, 214
- Punitive Parent mode, 10, 29, 33, 42–3,  
52, 70, 74–5, 104, 113, 125–6  
(PPM-1), 138–9, 155–6, 163, 166,  
213, 214 (PPM-2), 214 (PPM-3),  
213 (PPM 4), 213–23, 225–8  
Awareness and cognitive  
interventions, 213  
Experiential interventions, 215–17  
Mode role-plays, 217–19
- Randomized controlled trial (RCT), 3,  
286–94
- Rescripting, rewriting (*see* imagery and  
trauma), 97, 101, 170–74, 178–95
- Review in group, 101–2, 165, 226–8,  
245*t*
- Role-play, 20, 32–3, 70, 74–5, 94 (BEH  
ANT 4, 5), 99, 101, 154–5, 161–4,  
197, 207, 209, 216–17, 219, 221,  
269, 283
- Romantic involvements, 28
- Safety, 10, 28, 34, 44, 50, 66–8, 71–2,  
95–7, 132–40  
Safe Place images, 136–8  
Safety area of group space, 52, 85  
Safety Bubble image, 56, 134 (EXP 9)  
Safety imagery, 56, 101–2*t*, 132, 134  
Safety plan, 72, 80, 138
- Schema mode (*see also* mode)  
Definition, 3, 9–10, 116–26  
Empirical validation, 14  
Handouts, 166 (ED ST 4)  
Relationship to BPD, 119–22*t* (ED  
ST 6)  
Schema mode, 113 (ED ST-1)  
Schemas, definition, 8–21, 10*t*, 271–85,  
273–7*t*
- Schema theory – etiology PD, 9*f*, 116  
(ED ST-11)
- Schema therapy conceptual model,  
8–21

- Self-disclosure, patient, 67, 114
- Self-disclosure, therapist, 77, 179–83
- Self-injurious behavior, 14, 72, 139–40*t*
- Session, group
  - Beginning, 95–7
  - Ending, 100
  - Length, 83
  - Middle, 98–9
  - Timing guide, 101–2*t*
  - Wrap-up, 99–100
- Sexual abuse, 13, 50, 103, 115, 199, 214
- Sibling rivalry, 197
- Silence in sessions, 43, 87
- Size of groups, 80
- Stages of GST, 85–7
  - Stage One: Bonding and Emotional Regulation (*see also* Bonding), 106–42
  - Stage Two: Schema Mode Change, 143–225
  - Stage Three: Autonomy, 225–43
- Stigma BPD, 26
- Structural models of group therapy, 17–20*t*
- Stuck-ness exercise, 160
- Suicide attempts, 72, 139–40*t*
- Summary (*see review*), 101–2, 165, 226–8, 245*t*
- Temperament, 9, 13, 50, 62, 110–11, 116, 133, 149, 201
- Therapeutic factors of groups, 5, 20, 22–36
  - Impact on schemas and modes, 24*t*
- Therapists
  - Availability, 80
  - Behavior, 37–78
- Schema/mode activation, 63–4, 205, 224
- Single therapist groups (*see also* co-therapist team), 25, 44, 300
- Therapist Tips, 37, 62, 76, 112, 115, 132–6, 155, 166, 176, 187, 207, 211, 216
- Therapist tool kit, 85, 86*t*
- Touch, 48, 171–2
- Training, 1, 4, 20, 41–3, 78, 80, 163–4, 219, 266
- Transitional objects, 41–3, 80, 179, 198–200
- Trauma, 31, 73, 101, 107, 139
  - Limits to re-experiencing, 114, 187–8
  - Rescripting, rewriting endings, 115, 170–74, 178–95
- Treatment components, 257–8
- Universality, 25, 49–51
- Unstable relationships, 15
- Vicarious learning, 28, 74–5, 77, 192, 218
- Vocal tone, therapist, 47, 58–9, 171
- Voices, 214, 219–22
- Vulnerable Child mode, 124–5
  - (VCM 1), 163–204
  - Awareness work, 165 (AW 2-2, AW 2-5)
  - Behavioral pattern breaking, 200, 217–19
  - Cognitive interventions, 165–6 (ED ST 4)
  - Experiential interventions, 169

## Patient Workbook Materials

### Angry Child Mode

ACM 1, 125, 205  
ACM 2, 93, 206  
ACM 3, 198  
ACM 4, 206

### Awareness

AW 1-1, 2, 3, 92, 131, 132  
AW 2-1, 2, 3, 4, 5, 92  
AW 2-2, 200  
AW 2-4, 214  
AW 3-1, 2, 92

### Behavioral Pattern-Breaking

BEH 1-1, 2, 94, 140  
BEH 2, 3, 4, 94  
BEH 2-1, 2, 3, 4, 5, 142  
BEH 2-4, 223  
BEH 3-1, 200  
BEH 3-2, 223  
BEH 3-3, 142

### Behavioral Antidotes

BEH ANT 1, 94, 161  
BEH ANT 2, 94, 200  
BEH ANT 3, 94, 223  
BEH ANT 4, 94, 161  
BEH ANT 5, 94, 161  
BEH ANT 6, 94

### Cognitive Interventions

COG 1, 93

### Education

ED BPD-1, 111  
ED BPD-2, 111  
ED F 1, 127  
ED F 2, 129  
ED F 3, 127  
ED ST-1, 113  
ED ST 1-9, 93  
ED ST 1-11, 112  
ED ST 4, 112, 166  
ED ST-5, 112  
ED ST 6, 118  
ED ST-7, 126  
ED ST 11, 112, 116

### Experiential Interventions

EXP 1, 127  
EXP 2, 179  
EXP 3, 93  
EXP 4, 260  
EXP 5, 93, 168  
EXP 6, 260  
EXP 7, 260  
EXP 8, 260  
EXP 9, 71, 93, 134  
EXP 10, 71, 93  
Circle monitor, 72

### Healthy Adult Mode

HAM 1-8, 231  
HAM 2, 231  
HAM 3, 231  
HAM 4, 231  
HAM 5, 231, 236  
HAM 6, 231, 236  
HAM 7, 231  
HAM 8, 231

### Maladaptive Coping Modes

MCM 1, 123, 145  
MCM 2, 93  
MCM 3, 93  
MCM 4, 93

### Punitive Parent Mode

PPM-1, 125–6, 213  
PPM-2, 214  
PPM-3, 214  
PPM-4, 213

### Reference

REF 1, 90  
REF 2, 88  
REF 3, 262  
REF 4, 37  
REF 5, 142  
REF 6, 78

### Vulnerable Child Mode

VCM 1, 124  
VCM 2, 165  
VCM 3, 200