ISST
International Society of Schema Therapy

GREETINGS

It seems that 2020 should have come with a “trigger warning”

At a time when the COVID-19 virus is ravaging the world in different ways and to different degrees, we as Schema Therapists are faced with the imperative to not only do our part to keep ourselves, our families and our communities safe, but also to help our patients navigate these difficult and often triggering times. While in some parts of the world therapists may be practicing much as they always have, in other parts our members are seeing patients with much of our faces and our patients' faces cloaked behind literal masks. Others of us have had to rapidly alter our practices to accommodate telephone or video sessions using an array of platforms that we may not have been familiar with months earlier. This issue will focus on new ways to practice, new ways to think, and new ways to understand the rapid changes in our world through the lens of Schema Therapy.

In this issue, **Richard Brouillette** notes the mass traumas our planet is facing, including the "COVID-19 pandemic, climate catastrophes, authoritarianism and murderous racism" and wonders about how we cope with this shared-reality. He posits a "Social Adult" Mode, and further divides this mode into "Healthy Social Adult", and "Maladaptive Coping Social Adult". These modes are explored and elaborated.

Tracey Hunter has identified two schemas that are particularly activated by the current pandemic: Vulnerability to Harm/Illness, and Negativity/Pessimism. She offers both insights into the schemas, as well as ways to work with these schemas to help patients manage realistic worries and risks, while not being overtaken by distorted or exaggerated fears.

Jeff Conway considers Schema activation for those who have Schemas in the Impaired Autonomy and Performance Domain, focusing particularly on the Dependency and Incompetence Schema and the Enmeshment and Undeveloped Self Schema.

Maria Grishkina, Emma Agasaryan discuss the particular impact of quarantine and extended isolation on patients with Cluster C disorders. Noting that the pandemic and quarantine/isolation affect not only patients but also therapists and all health care professionals, the authors discuss struggles encountered by therapists at this time, including our own schema activation. They describe challenges to the therapeutic relationship, and conclude by proposing strategies to mitigate the effects of the pandemic on Cluster C patients.

Ilona Krone, Alexandra Yaltonskaya and Darya Maryasova present their very timely work using Video Feedback to strengthen the Healthy Adult Mode and enhance mode work.

Finally, **Vivian Francesco** "introduces" us to **Arnoud Arntz,** Honorary Scientific Adviser of the International Society of Schema Therapy.

As always, if you have suggestions for future newsletter topics, or ideas of articles you'd like to submit, please contact us. Stay well, stay safe.

Lissa Parsonnet (USA), Susan Simpson (Scotland)
Pam Pilkington (Australia), Tena Davies (Australia) Co-Editors

THE SOCIAL ADULT MODE:

A THEORY FOR A TIME OF GLOBAL CRISES

Richard Brouillette, LCSW

> To be a Negro in this country & to be relatively conscious, is to be in a rage almost all the time. So that the first problem is how to control that rage so that it won't destroy you.
>
> James Baldwin (1)

> There's no acknowledgment of the death and the suffering, and that's politically motivated," said Quinn. "They want to brush the deaths under the rug. They want to 'downplay' it, in Donald Trump's own words, and we've been robbed of mourning.
>
> We Aren't Nationally Mourning The 200,000 COVID-19 Victims Because If We Did It Would Be A Reckoning
>
> Buzzfeed News (2)

Healthy Social Adult Mode:

A mindset of seeing oneself with the strength, resilience, agency and the ability to engage with catastrophic reality, either as part of a social group, or in response to the failures of a social group, with the goal of providing for threatened needs at both the individual and mass level.

THE POLITICS OF THERAPY AND MASS CRISES

What happens when catastrophic events outside the therapy office exert a powerful emotional force on our clients? For the mental health profession, this may be the question of our time. Consider the above quotes: the anger of James Baldwin, or the grief of a son who lost his father to COVID and whose mourning has been denied for political reasons. How can therapy help with their pain while avoiding the pitfall of "curing" them of a valid reaction to injustice? In anxious times of outrage, it's only right to feel outrage and anxiety as calls to action. But can schema therapists help their clients cope with catastrophic crises in the world without losing their clinical neutrality? I suggest we need to tackle this question, or face being mute when our clients are in profound need as the global condition worsens.

This is a time of mass traumas, including the COVID-19 pandemic, climate catastrophes, authoritarianism and murderous racism. We are all learning to cope with the previously unthinkable, to conceive of profound changes to the nature of lived, shared reality.

Two months into the pandemic, one of my clients described sitting on a stoop in the East Village of New York City, eating cheap take-out curry, weeping, pondering the possible closing of his favorite little Indian restaurant (yet another loss), as he looked up an abandoned First Avenue, trying to put off going back to his apartment and crushing loneliness. During a session with another client, an activist in the anti-racism movement: he received word that hundreds of protestors were being "kettled" on the Manhattan Bridge, trapped on both sides by police, and worried aloud that they would be massacred. Another client came to session preoccupied with Trump's recent refusal to commit to a peaceful transfer of power. "I have some ancestors who decided to leave Europe as Hitler came to power, and some who decided to stay. The ones who stayed died. What do I owe them, and when do I decide when to take my family and leave?" As a therapist, I have an uncanny internal experience during such discussions: "This cannot be happening, surely, it's not as bad as this…but if it is as bad as this, then we are all helpless." It's a triggering experience, and a chilling challenge for any healthy adult mode. We are in a time when reassurance is hard to muster.

It is at this point of triggering, for my clients and me, that we might imagine a new mode, one offering strength and resilience, and a clear sense of how to take protective, collective, caring action: Healthy Social Adult Mode.

In the context of catastrophe, there is no place left for a client to go with their troubles other than out into the community, where reality only changes based on collective actions. Now is an opportunity for schema therapists to conceive of the various modes our clients may operate in at the collective or social level, and help our clients imagine and practice being in healthy modes in order to address their needs.

We might call these the Social Adult Modes, with two categories: Healthy Social Adult and the Maladaptive Coping Social Adult Modes.

In clinical examples including people coping with COVID-19, climate catastrophe, and authoritarian racism, our clients would likely benefit from the option of bringing their individual pain into a shared community space, with the aim of making change. Only then do they experience their pain as being heard. Collective action and mutual aid are the most effective interventions in coping with police violence and racism, the brutal effects of the pandemic, and the violence of climate catastrophe. Schema therapists are uniquely placed to help clients conceive of their social selves with the mode concept and therapy that moves them from maladaptive coping (denying reality) to healthy coping (accepting reality and acting).

At this point, therapists following this argument would no doubt feel anxious. "Am I supposed to direct my clients to take social or political action?!" This is indeed delicate ground in terms of respecting clinical neutrality and avoiding too much personal influence over clients. This challenge, though, should be no different than the challenge of avoiding undue influence in the context of personal issues in therapy, like, say, marriage problems. It has become imperative that we imagine the range of options our clients have to fulfill their needs in social space— just as we already provide options for them in interpersonal spaces. When we work at the individual level with clients, say, on relationship skills or assertiveness, we identify and label modes which influence their behavior, and work with them. We may also help them imagine a new aspect of the self, their Healthy Social Adult Mode. With the concept of a Social Adult Mode as a tool, we can equally help build client insight into their coping reactions at the level of major social events, and help guide them through based on their own identities and priorities.

SOCIAL ADULT MODES AND REALITY-ALTERING CATASTROPHE

The clients I shared earlier all have a common experience: they feel there is no longer an "adult in the room," meaning the authorities and people in charge of our safety are incompetent, ineffectual, or worse: actively worsening the situation at our peril. In the case of systemic anti-blackness, there is the feeling that the adults in the room are actually a threat to existence. I liken this experience of losing the "adult in the room" at the collective level to what a child experiences individually, when they realize that their parents are incompetent or willfully negligent; "I'm vulnerable and there's no one coming to save me, I have to somehow take care of myself." A profound sense of vulnerability and helplessness is triggered.

Now, at the individual level in childhood, this would be the point when modes form and evolve. This is no different with the onset of reality-altering global events. Feeling exposed and vulnerable, our clients need modes to help them adapt in new ways. Social modes are what happens when clients react to major social threats. They may find that they are relating and connecting with others in new ways, different from usual interpersonal experience. They may also fall into social modes which are maladaptive and avoidant, even aggressive and hateful.

I propose at least four major Social Adult (S/A) Modes have formed in recent years in response to climate change, the mass failure of global financial policy to address basic needs, the rise of racist authoritarianism, and most recently the pandemic, i.e., unmet social needs. Each S/A Mode expresses a reaction to our shift in the nature of social reality. Notice the Healthy S/A is the one mode which accepts the truth of massive changes in the world while the other modes are maladaptive:

- **Healthy S/A.** Accepts real threats to survival, considers action to protect self and family, including changes in behavior, migrating, or joining collective action to make systemic change, motivated by feelings of righteous anger and outrage.

- **Bully/Attack S/A.** Denies science and reality, including significance of weather events, COVID-19 casualties, prone to the influence of authoritarianism and tribalism, motivated by anger, grievance, resentment.

- **Avoidant Protector S/A** Committed to the status quo, willing to disregard major efforts to make systemic change as "unrealistic" despite science of reality of threat, often occupied by authority figures motivated by a deep personal stake in status quo.

- **Detached Self Soother S/A** Detaches from major threats often due to racial and economic privilege; invested in daily status quo of self and family, dissociated from experience of being part of a community, motivated by conflict avoidance and need to avoid feeling culpable.

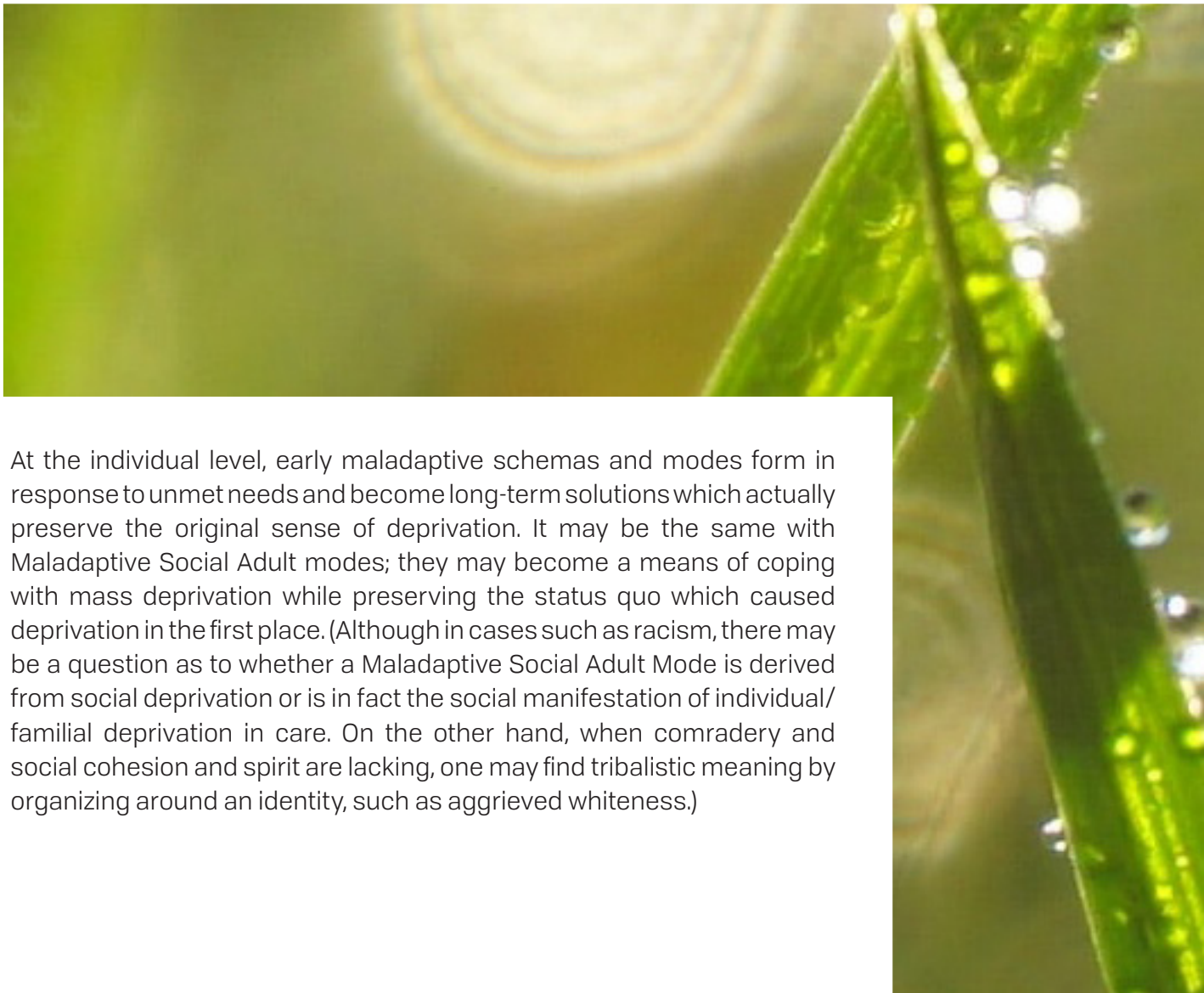
Of course, the implication of there being a Healthy S/A and other, maladaptive S/As is that our clinical goal is to move clients in the direction of the healthy, to adapt to the facts of lived reality, risk, and threats, so that they can realistically adjust and take action however they see fit.

CLINICAL USE OF SOCIAL ADULT MODES

The Social Adult modes are born out of unmet core social needs, just as schemas and modes are the result of unmet core emotional needs at the individual level. The clinical process of work with Social Adult modes is to help clients connect their experience of unmet core social needs with a reality-based state of mind geared toward addressing them.

Core Social Needs include:

- Safety, Security and Healthcare
- Autonomy, Respect and Dignity
- Meaningful Democratic Involvement in Social and Economic Process



At the individual level, early maladaptive schemas and modes form in response to unmet needs and become long-term solutions which actually preserve the original sense of deprivation. It may be the same with Maladaptive Social Adult modes; they may become a means of coping with mass deprivation while preserving the status quo which caused deprivation in the first place. (Although in cases such as racism, there may be a question as to whether a Maladaptive Social Adult Mode is derived from social deprivation or is in fact the social manifestation of individual/familial deprivation in care. On the other hand, when comradery and social cohesion and spirit are lacking, one may find tribalistic meaning by organizing around an identity, such as aggrieved whiteness.)

My preliminary trials of work with the Social Adult Mode concept with my clients have taken the form of three phases:

1

Accept Catastrophic Reality at Individual Level. First, I work with a client on those individual modes which prevent them from being able to accept what they are experiencing in the world: "I can't believe people are being treated like this and that could be me." This may involve grief work, a panicky vulnerability schema, or even a punitive schema having the client blame themselves for not seeing it sooner. Please note, I am assisting a client in "seeing what they see" without necessarily suggesting what they "should" see. This stage is more about the psychological work of accepting a social or civilizational paradigm shift the client has already taken in.

2

Transcend Maladaptive Coping Social Adult. Second, if clients move toward a Maladaptive Coping Social Adult mode, help them address the contradictions and stress the mode causes in the client's lived experience.

3

Imagine and Practice Healthy Social Adult Mode. Once a client is further along in the process of accepting new facts, the vision of a Healthy S/A mode becomes a path for them to develop a broad, renewed sense of self-care and find motivation in powerful feelings related to awareness of the catastrophes in the world.

CULTIVATING THE HEALTHY SOCIAL ADULT MODE

I found Farrell, Reiss and Shaw on the Healthy Adult Mode to be very instructive by adapting their mode work to the context of the Healthy Social Adult Mode. (3) The key difference between Health Adult and Healthy Social Adult is the context of individual vs social. While the individual Healthy Adult is concerned with self-care and fulfilling relationships with others in personal life, the Healthy Social Adult is concerned with their role in social and public settings and relationships. The Healthy Adult engages in dialogue with the other modes in order to have a sense of identity, self-control, and emotional fulfillment, while the Healthy Social Adult manages modes in order to expand a sense of identity, self, and values specifically in settings related to handling mass catastrophic events.

I'll adapt some mode exercises from Farrell, et. al., to illustrate:

Getting to Know Your Healthy Social Adult (H/SA) (Cognitive Intervention)

* What issues are motivating your H/SA?
* How do you imagine your H/SA getting involved (pretend that the usual inhibitions you feel are gone for now)?
* How do you see your H/SA interacting with others? As a leader? A follower?
* Can you imagine finding mentors and friends in the social setting you are part of?

Behavioral Experiments for the H/SA

* Which H/SA behavior do you want to test out? (Volunteering, planning a migration plan, speaking to a representative of an activist group)
* How did you feel after your test? What were the challenges?
* What were the benefits of your experiment, ways you felt fulfilled, proud of yourself, etc.?

Your H/SA and the Future (Experiential Intervention)

* What is the ideal future you would like to see for the world, if your work was successful? Imagine talking to your grandchildren about what you did during this time and how it helped them.
* Where do you imagine your H/SA in the future? What role are you playing in your community? Are you influencing others or mentoring others?

CONCLUSION: NEUTRALITY PRESERVED

When our clients are confronted with catastrophic or mass threats and traumas, schema therapists currently have limited options in response, aside from validating thoughts and feelings and exploring how schemas and modes may be triggered and working with grief. By staying focused on the individual level with such issues, therapists risk actually having an unintended political effect by reducing those feelings a client may need to address the problem. The theory of the Health Social Adult may be a tool schema therapists need to help clients manage mass social trauma, thereby actually maintaining clinical neutrality.

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ACTIVATION OF THE VULNERABILITY TO HARM/ILLNESS SCHEMA AND NEGATIVITY/PESSIMISM SCHEMA DURING THE COVID-19 PANDEMIC

Dr. Tracey Hunter

Schemas, when unhealed, can lay dormant and undetected when there are no immediate environmental triggers to activate them from their slumber. For example, an abandonment schema could lay dormant in someone who avoids close relationships, and it only becomes activated when the threat of abandonment is a possibility in a committed relationship. A failure schema could lay dormant in someone who is routinely achieving perfect grades, until they are placed in a setting where they have not yet achieved mastery of an unfamiliar task (such as a new job).

ACTIVATION OF THE VULNERABILITY TO HARM/ ILLNESS SCHEMA AND NEGATIVITY/PESSIMISM SCHEMA DURING THE COVID-19 PANDEMIC

Dr Tracey Hunter

Two schemas that appear to have been activated on a widespread scale as a result of COVID-19, are the Vulnerability to Harm/Illness schema and the Negativity/Pessimism schema. The aggressiveness and psychological impact of unhealed schemas is especially apparent in some countries such as here in Australia, with a very low infection rate in comparison to other countries. However, the surge in demand for psychotherapy in response to the uncertainty and potential threat of COVID extends far beyond the physical impact of the disease for the majority of the population. This heightened degree of perceived threat, anticipatory anxiety, fear and uncertainty about the future as a result of COVID makes the current situation a breeding ground for schemas to be activated and to resurface.

THE UNCERTAINTY AND POTENTIAL THREAT OF COVID EXTENDS FAR BEYOND THE PHYSICAL IMPACT OF THE DISEASE

In the current climate of clients seeking psychotherapy in relation to stress triggered by COVID, it is helpful to first rule out whether the anxiety experienced by the client is not schema-driven, but rather as a response to the actual risks, threats and concerns that the client is currently processing (eg. proximity to high rates of infections, pre-existing conditions, vulnerable family members, job loss or income reduction, frontline workers etc). Alternatively, a client's heightened anxiety could be purely schema-driven, such as unprocessed trauma linked to a VHI schema in which the client experienced illness, trauma, catastrophe or natural disaster that is yet to be processed and integrated.

In the case where the client's anxiety is focused on health vulnerability, fears about contracting COVID, or heightened focus on bodily symptoms and illness, and the anxiety appears to be more schema-driven (i.e., less connected to real-life experiences with COVID), the therapist may consider whether the Vulnerability to Harm/Illness schema has been activated and needs to become a focus for the therapy.

ACTIVATION OF THE VULNERABILITY TO HARM/ ILLNESS SCHEMA AND NEGATIVITY/PESSIMISM SCHEMA DURING THE COVID-19 PANDEMIC

Dr Tracey Hunter

The Vulnerability to harm/illness (VHI) schema is described by Jeffrey Young as:

"Exaggerated fear that imminent catastrophe will strike at any time and that one will be unable to prevent it. Fears focus on one or more of the following:
(A) Medical Catastrophes: e.g., heart attacks, AIDS;
(B) Emotional Catastrophes: e.g., going crazy;
(C): External Catastrophes: e.g., elevators collapsing, victimized by criminals, airplane crashes, earthquakes"

The VHI schema can develop through direct past experiences, such as in a client who as a child experienced an illness that required intensive medical treatment, and there were prolonged messages of concern about recovery. This VHI could be classified as a type of trauma response, as the threat to safety or life may have been very real, activating the parents, caregivers, medical staff and teachers to be on hyper-alert and communicate their own fears and concerns to the child regarding the child's vulnerability and risk.

In addition to the client's own personal history, a more indirect pathway to developing the VHI schema, is through intergenerational trauma, whereby a parent experienced illness, harm or catastrophe in their childhood, and due to not having processed their own trauma, unconsciously passed the VHI schema onto their child, by viewing all health issues, accidents and injuries, or even general threat and uncertainty, through the schema lens of their own past, rather than their child's individual reality. Therefore, the child may then go on to develop the VHI schema by internalising the parent's projected anxious narrative about life being threatening, and developing an Internalised Over-anxious Parent Mode in relation to any health issues that involve a degree of uncertainty and chance of risk.

Therefore, in the case of a client whose anxiety seems to be largely schema-driven and focused on the physical threat of the disease, exploring the origins of the client's VHI schema will be extremely useful in the therapy direction, to understand whether it is the client's own experience of vulnerability to harm or illness during childhood, or unhealed trauma from the client's parent(s) that is at the core of their schema.

In situations where a client experienced trauma, illness, uncertainty, heightened risk, or lack of security and safety, we can easily imagine such a child turning towards a parent-figure to seek comfort and safety, and also as a source of authority and absolute truth, in order to form their judgement on whether they should feel safe or threatened about their health and likelihood of survival. If the child's illness experience was also paired with an over-anxious or pessimistic response from the parent-figure during this time of uncertainty, then these clients will benefit greatly from limited reparenting that focuses on validating the absence of the child's core needs for solutions, for reassurance, for comfort and better emotion regulation and self-control on the parent's part. The client will likely benefit from a therapeutic approach that is both nurturing in the validation of the uncertainty and lack of safety experienced in their childhood situation, whilst setting limits on the schema-driven Over-Anxious parent mode, thereby creating more differentiation between the past and the present.

In a Schema Therapy approach, the therapist can help the client differentiate between the experience of the Vulnerable Child mode, who may believe that any chance of risk is a sure sign of danger and threat to them personally, versus the Healthy Adult mode who can observe the personal historical narrative underlying the schema, make the links between current anxiety symptoms and past experiences, and have compassion for how frightening it must have been for a child to experience illness or catastrophe and to endure an undefined period of threat. One way to strengthen the Healthy Adult mode might be to ask the client what daily practices would cause them to feel more safe in an uncertain world. The therapist could say "Given we are in a time of uncertainty here, and there are so many factors outside of our personal control, such as other people's actions, government decisions, or even knowledge of how the disease will play out, what are some choices or actions that give you a better sense of control or certainty?". This could include health-based practices that are within the control of the client (such as nourishing food, sufficient exercise or fresh air, sunshine, play, rest, social support and sleep), or choices such as whether to wear a mask or not, whether to avoid crowds or not, what time of day to shop, and what physical environments feel safe versus unsafe to them. These choices could be re-affirmed by the Healthy Adult by saying: "I feel good knowing that I can create some safety for myself by (chosen activity), even amongst all this uncertainty. I can also see how unprocessed memories from my past about illness and/or catastrophe heighten my sensitivity to potential threat and uncertainty".

any chance of risk is a sure sign of danger and threat to them personally

In terms of behavioural pattern-breaking, watching too much of the media and news reports on COVID will perpetuate the activation of the Vulnerable Child mode, and the voice of the Internalised Over-Anxious Parent mode shouting: "Watch out! You're under threat! Life is not safe!" - since news stories only focus on negative storylines, reporting of death figures, and economic loss and instability. Routinely turning towards outside authorities such as the news reporters, some politicians, and even some medical professionals can leave clients feeling disempowered or overly dependent on external sources of authority over their own internal Healthy Adult mode, and they may benefit from developing a greater sense of agency and autonomy over their lives and day-to-day choices and decisions.

ACTIVATION OF THE VULNERABILITY TO HARM/ ILLNESS SCHEMA AND NEGATIVITY/PESSIMISM SCHEMA DURING THE COVID-19 PANDEMIC

Dr Tracey Hunter

Also, the images played on the news channels are not easy for the majority of people's nervous systems to digest, let alone people with schemas (healed or unhealed) such as vulnerability to harm/illness, negativity/pessimism, or mistrust/abuse, which are all schemas that activate anxiety and the sympathetic nervous system. For clients with a VHI schema, being exposed to the news is likely to be re-traumatising for the Vulnerable Child mode. The healing of this schema should include limits on exposure to content that triggers instant feelings of threat and harm, such as the news, and balancing this with exposure to content that is reassuring or comforting, including positive news channels.

A second schema that has been widely activated as a result of the COVID-19 pandemic, is the Negativity/ Pessimism schema. This schema can be seen in people that have become highly concerned or even grim about their own future, especially with regards to their financial stability and job security, and possibility of recovering and thriving in the future.

The Negativity/Pessimism schema is described by Jeffrey Young as:

"A pervasive, lifelong focus on the negative aspects of life (pain, death, loss, disappointment, conflict, guilt, resentment, unsolved problems, potential mistakes, betrayal, things that could go wrong, etc.) while minimizing or neglecting the positive or optimistic aspects. Usually includes an exaggerated expectation-- in a wide range of work, financial, or interpersonal situations -- that things will eventually go seriously wrong, or that aspects of one's life that seem to be going well will ultimately fall apart. Usually involves an inordinate fear of making mistakes that might lead to: financial collapse, loss, humiliation, or being trapped in a bad situation. Because potential negative outcomes are exaggerated, these patients are frequently characterized by chronic worry, vigilance, complaining, or indecision".

This schema is another schema that has lay dormant in many people, only to be activated by the uncertainty and economic impact resulting from COVID-19. Again, it is worthwhile to firstly assess whether the NP schema is active in a client versus current and actual stressful events that have no solution. This can be done by exploring the degree to which the client is overly focused on negative outcomes that have not yet occurred, in comparison to their actual current situation and the solutions available to them. Even for people who have lost their jobs due to the COVID-19 pandemic, the NP schema will have a strong influence on the mindset or outlook that the person takes with regards to problem-solving, optimism about getting re-employed in the future, or using creative new ways to manage finances, versus ruminating on a future that they do not wish to come true. The Healthy Adult mode has an important role in the healing of the NP schema, by taking ownership of their desires, values and goals for the future, allowing themselves to feel some hope or excitement, and taking steps towards these outcomes, even in the face of adversity and the potential for disappointment.

Exploring the origins of the NP schema will be therapeutic for clients, and we can use Socratic questioning to inquire about where the client first learned to adopt a pessimistic outlook for their future. This inquiry may reveal actual trauma or events in the client's childhood that did not result in a solution or recovery (e.g., a parent lost their job and became alcoholic and the parents separated, with no further contact from one parent), or again this schema may have developed intergenerationally (e.g., the client's parent experienced child abuse, war, poverty, migration that resulted in alienation, etc) but due to not having processed the trauma, the parent projected their depression and pessimistic view of life onto the child.

In the case of the latter, the client may benefit from an imagery or chair dialogue where the therapist empathises with their parent's past trauma, but also sets gentle limits on the parent with regards to using self-control and not projecting their experience onto their child, and also the importance of creating a sense of hope and opportunity for a positive life and future for their child (the client).

Finally, the healing of both the VHI schema and the NP schema can also benefit from a chair dialogue where the therapist sets limits on the unfiltered anxious reactivity of the Over-anxious Parent Mode that keeps drawing the client's focus to negative external events that are not within the client's immediate control. This dialogue may be along the lines of: "I understand you are worried and anxious, and you feel it's your job to alert Jane to all the possible threats to her safety, but you are constantly giving her a message of threat and harm, and you are not giving her solutions or any hope of safety and security. I need you to stop all the uncontained fear-based messages, so that Jane's Healthy Adult can stay focused on her wellbeing, and on the things that are in her power to control, and on the immediate choices that are going to support her to feel safe and secure".

Dr. Tracey Hunter
Schema Therapist, Australia

By Jeff Conway

AUTONOMY, ATTACHMENT, AND A PANDEMIC

We are experiencing a rare occurrence in our world, in which one event, the COVID-19 Pandemic, is impacting virtually everyone. Some of us have been negatively impacted in such dramatic ways as temporary or prolonged loss of health, loss of work and/or financial stability, or the most profound loss – that of a loved one or one's own life. Many others have been impacted less harshly, dealing with a mix of some minor inconveniences and isolation. Some have experienced unexpected good fortune and discovery. But all have been impacted directly or indirectly.

On a psychological level and in Schema Therapy terms, this has been a time of high Schema activation from all the four Domains of Unmet Needs. Whether the domain of Disconnection & Rejection, Impaired Limits, Excessive Responsibility & Standards, or Impaired Autonomy & Performance, people have experienced these Schemas in an intense way. This article will consider the Schema activation for those who have Schemas in the Impaired Autonomy and Performance Domain, particularly the Dependency and Incompetence Schema and the Enmeshment and Undeveloped Self Schema.

When the pandemic hit and most of the world came to a big slowdown for an extended period, several opportunities had faded completely, while other choices were limited or rendered undesirable. If you still had a job, traveling to work was probably not an option. If you often visited with friends and family, the traditional way of doing so largely vanished. Going to such indoor spaces as a mall, a grocery store, a museum, or a gym, were made impossible or imbued with so much danger that the various options seemed too fraught to be realistic choices. Because of these changes, many of the routines of life that we might have complained about once upon a time, routines that also provided us with a kind of security and stability were instantaneously altered or eliminated completely. And these changes arrived with no clear indication about when normalcy would return.

At the start of the pandemic, even our ability to make thoughtful choices was seriously undermined. The guidance of how to best protect oneself and loved ones was confusing and contradictory. No need to wear a mask or always wear a mask? Never enter public indoor spaces or enter such spaces if one used caution and protection? Precautions are unnecessary as the risk is not that serious, or the virus is much more dangerous than the experts are telling us.

Many of us had to contend with the reality that important plans and events were indefinitely sidelined. One young man complained that his career mobility was on hold because his industry had paused hiring. Another client had to scuttle his 50th birthday bash. A client who waited years to finally have all her children in school, thereby giving her some much-needed time for other goals and tasks, found herself in an even more crowded household with more responsibilities. Someone else who finally got a job in the area she wanted to work was unceremoniously furloughed once the pandemic began, leaving her to hustle and find any job that would generate income.

AUTONOMY

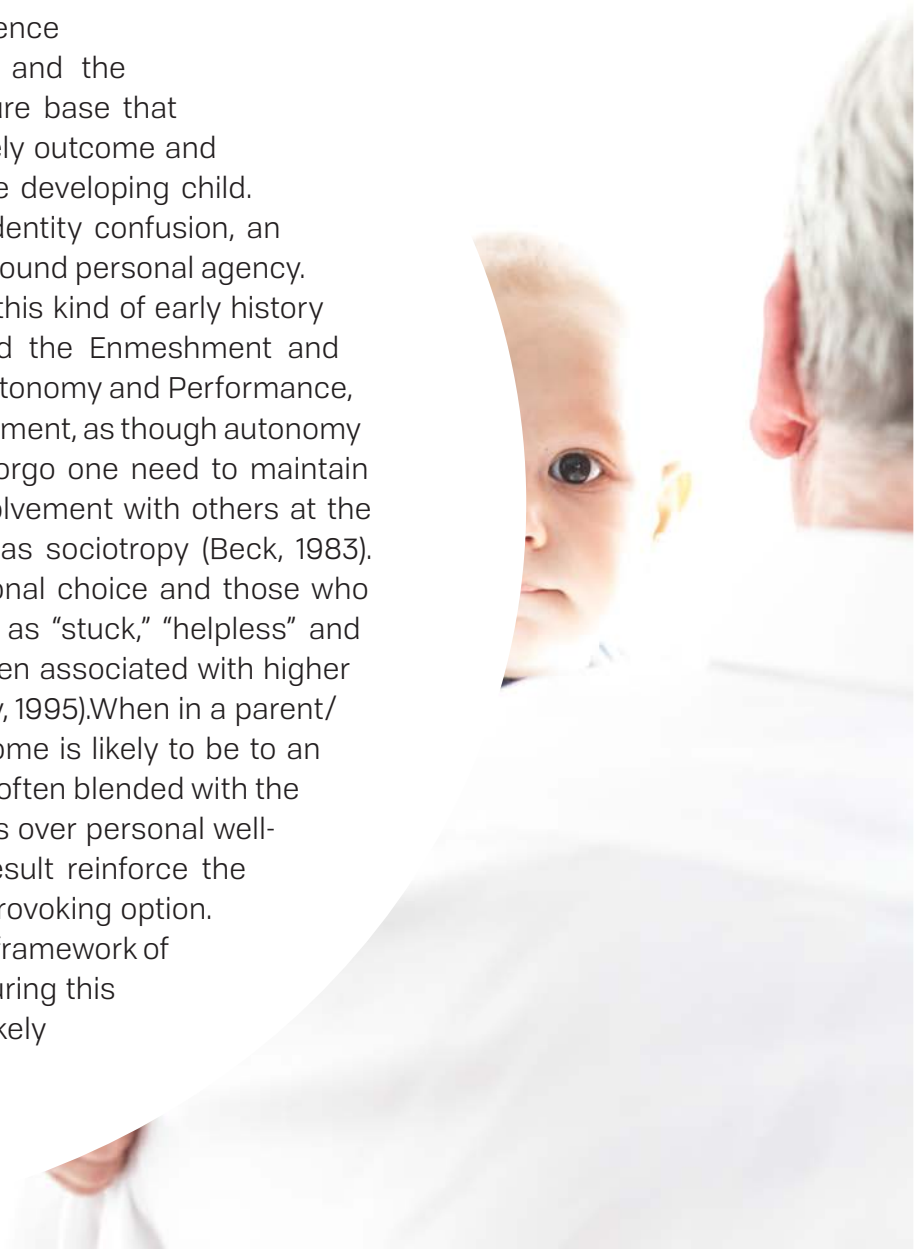
Autonomy is a basic need that we all have before we can even pronounce the word autonomy; and it exists throughout our lifespan to our final days. Simply put, it is a person's ability to self-govern. It is the ability to assert a sense of agency and to allow intrinsic motivation to be a guiding force in life. We are neurologically wired to be autonomous, just as we are neurologically wired to form attachments with others (Siegel, 1999). We want to choose how we play and how we work, and with whom we interact with. We feel compelled to explore our inner and outer world to gather useful data that will inform our life choices.

"Autonomous individuals are characterized by self-governance; awareness of and capacity to realize one's wishes and needs, while being connected with and sensitive towards others" (Kunst, Maas, Van Assen, Van der Heijden & Mekke, 2019). In our Healthy Adult Mode, we desire a freedom of expression of our thoughts and feelings and to make all the choices that we think will lead to a meaningful, secure, and satisfying life. All the while working to maintain an interest in and value about the well-being of others. This includes how we engage with others, how we want to treat others, and how we want to be treated by them. For many of us, choosing who we decide to form a primary, intimate partnership with is an important example of agency. And within these sweeping decisions, there are smaller daily decisions that have to do with what we wear and how we organize our day. Some of our decisions, whether large are small, are a source of pride, while others are tinged with ambivalence and regret. But whether we are pleased or disappointed by any given decision, we know that the thoughts and actions we take are ours to own and that reality and evidence of personal agency instills in us a much needed sense of vitality and empowerment.

Schema Therapy has been greatly influenced by Bowlby's Attachment Theory. A central tenet of Attachment Theory stated that the most essential duties of a parent were to give care and nurturing to the child and to foster the child's innate need to explore the world (Bowlby, 1977). These are the necessary components of a secure base, which can be understood as a sense of safety and certainty of needs being met, created by caregivers in relationship with a child. This secure base is then internalized in the child throughout his/her lifespan and signals safety and comfort in giving and receiving care to others and in expressing agency in the world. In Schema terminology, such Early Adaptive Schemas related to the fostering of autonomy of the secure base include Healthy Self-Reliance/Competence and Healthy Boundaries/Developed Self (Lockwood & Perris, 2012).

SCHEMA DEVELOPMENT

But when a child does not receive a consistent experience of care and nurturing and guidance and the fostering of freedom to explore, an insecure base that is core to the parent/child relationship is a likely outcome and this insecure base is then internalized within the developing child. Some of the qualities of this insecure base are identity confusion, an amplified sense of abandonment and intense fears around personal agency. Two of the Schemas that are often engendered from this kind of early history are the Dependency and Incompetence Schema and the Enmeshment and Undeveloped Schema. As described in the Domain of Autonomy and Performance, asserting autonomy is weighed down by a fear of abandonment, as though autonomy and attachment are mutually exclusive, and one must forgo one need to maintain the other. There is an excessive preoccupation and involvement with others at the expense of a fuller autonomy, which has been defined as sociotropy (Beck, 1983). Such exaggerated attention to others undermines personal choice and those who struggle with this tendency often describe themselves as "stuck," "helpless" and "having no options." Understandably, Sociotropy has been associated with higher vulnerability for anxiety and depression (Alford & Gerrity, 1995).When in a parent/child relationship, autonomy is undermined, the outcome is likely to be to an imposed call to be constantly hyper-aware of others, often blended with the pressure to overly leverage the well-being of others over personal well-being. The Early Maladaptive Schemas that result reinforce the sense that self-governing is a highly anxiety-provoking option. When an event occurs in which the familiar framework of choices changes suddenly, as it has during this pandemic, these Schemas are likely to be highly activated.



At the point when any Schema is triggered, lies the possibility for reenactment and perpetuation or a corrective experience and healing.

SCHEMA ACTIVATION & TREATMENT

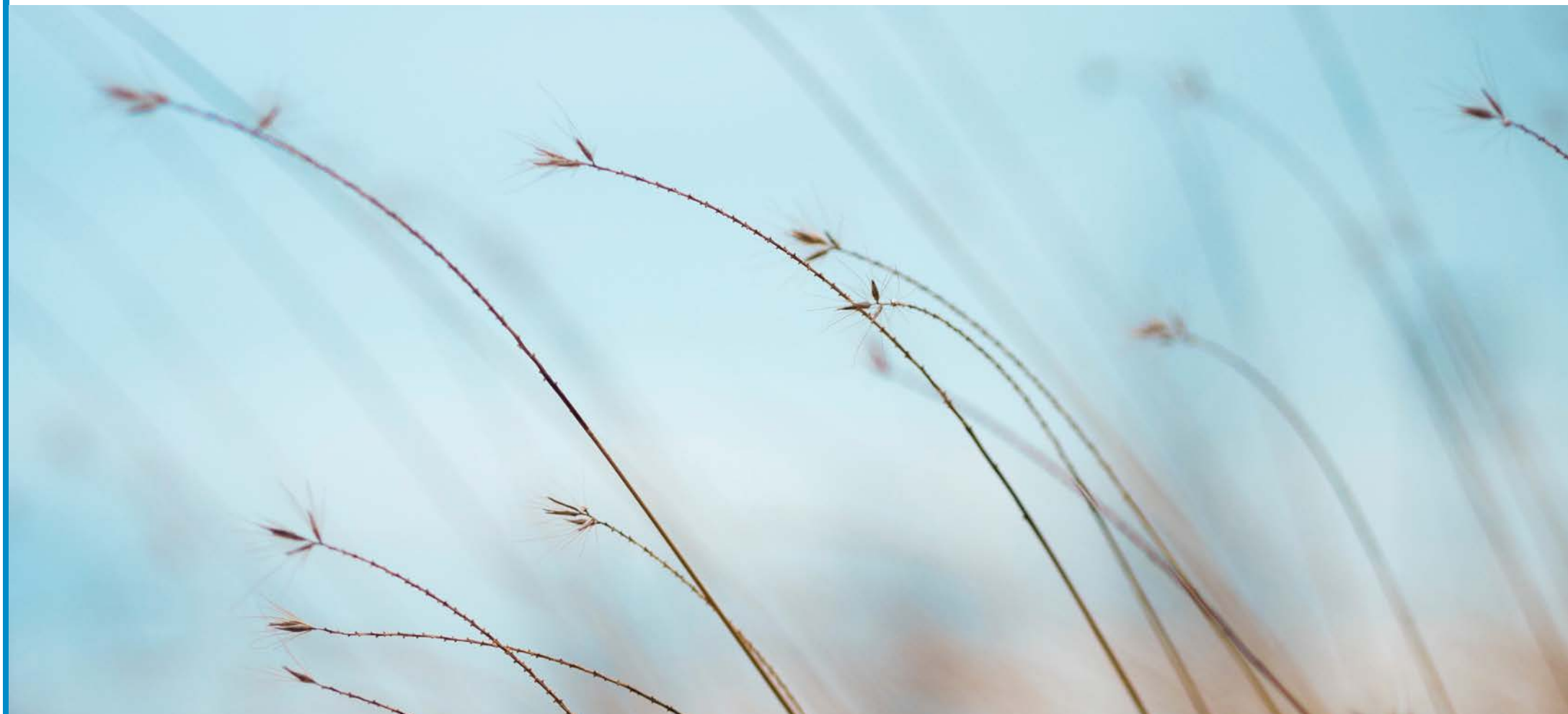
The path of least resistance is Schema perpetuation as it is heavily directed by the strength of the Schema, which beckons the person with the ego syntonic force of emotion, cognitions, memories, and bodily sensations. This creates an internal pull in the direction of succumbing to the schema and behaving in a certain Mode or set of Modes that perpetuate the schema. It is the powerful siren call leading to the rocks of a familiar but ultimately unpleasant outcome. Breaking out of the groove of that Schema towards a more realistic understanding of self and other and more empowered choices is the work of the collaborative Schema Therapy relationship.

Steve is someone I work with who has a high Enmeshment and Undeveloped Self Schema. Back in March, he expressed a high level of anxiety about the well-being of his primary partner (Greg) and his parents. He insisted that he and his partner take their temperature 5 to 6 times a day, spent much of the day wiping down doorknobs and flat surfaces, and compulsively studied the safest options for bringing food into the house. He begged his partner not to go outside without him so that Steve could monitor how careful his partner was being, which was driving Greg to distraction. Steve was also calling his parents many times throughout the day, inquiring of their health, and forbidding them to venture outside.

His exaggerated worries about his partner and his parents were almost completely at the expense of all else. When Steve was not trying to act on behalf of Greg or his parents, he was often thinking of them and the worst-case scenarios that could befall them. This was impacting his own self-care and his ability to adapt to doing his work online. He was distraught.

My work with him focused on his Vulnerable Child and our Limited Reparenting relationship. I helped him understand what Little Steve was emotionally experiencing – confusion, terror, and anxiety – and I helped him understand the reasonable "here and now" context for that emotional reaction. In addition, the Enmeshment Schema infused reaction was exacerbating the undeniably troubling situation he was experiencing. I encouraged him to consider what was going on in our therapeutic relationship and to try not to overly focus on Greg and his parents. I asked what he needed, and he was able to state that he needed some sort of reassurance. I offered the kind of reassurance that I felt was reality based. I did not paint a rosy picture, but one that I believed was plausible and not too dire for Steve or the people he cared about to endure.

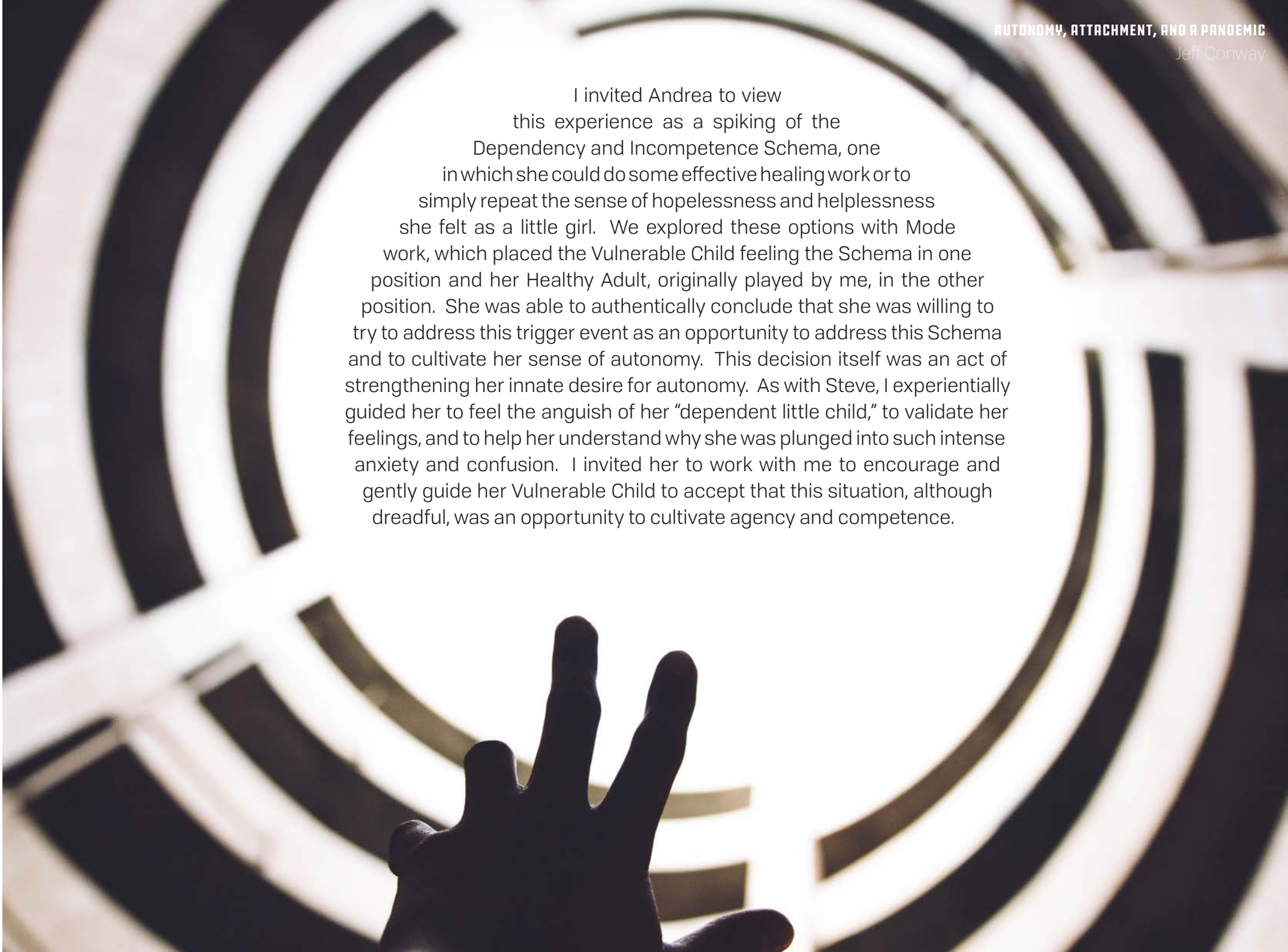
In a calmer state, I encouraged Steve to reality test how much his partner or parents needed his constant intervention and conceptualized for him what I thought was happening from a Schema and Mode perspective. That is, his Vulnerable Child sought to feel safe when anxious by making sure others are safe, much like he did as a little boy with regards to his parents. And in a time of perceived danger, Little Steve employs his Compliant Surrender to do this kind of extreme caretaking based on an exaggerated sense of the needs of others and to calm his anxiety. What I invited him to do experientially is let me and his Healthy Adult soothe and hold his Vulnerable Child and then refocus Steve to reality test what Greg and his parents actually need and to balance that with what (Adult) Steve believed he needed. This way, Steve can more closely provide what is needed, as well as find the choices that Steve can make that would serve his own well-being.



Andrea was more plagued by the Dependence and Incompetence Schema. She grew up in a family in which her life was overly managed by parents who thought she needed constant guidance and reassurance, unintentionally undermining her ability to think and do more for herself. Now that her parents were deceased, she looked to others to give her the constant guidance that she grew accustomed to in her youth. This was also a primary way she attempted to feel connected to others, even though her attempts to receive help and guidance were perceived as signs of neediness that caused many to pull away from her.

She had worked hard on healing this Schema and to find more Healthy Adult ways to find connection with others through building a foundation of understanding and negotiating personal needs. But her progress came to a temporary standstill when the pandemic hit. She felt tremendous fear and confusion in reaction to the pandemic and expressed helplessness in her ability to live her life in any way like how she lived before the pandemic. She was constantly soliciting guidance and support from me and her small circle of friends. By the first month, she simply chose to stay inside and not venture out of her apartment for anything. Her anxiety about the situation was a constant, and texts and emails to me recorded her plight and her desperation daily.

I invited Andrea to view this experience as a spiking of the Dependency and Incompetence Schema, one in which she could do some effective healing work or to simply repeat the sense of hopelessness and helplessness she felt as a little girl. We explored these options with Mode work, which placed the Vulnerable Child feeling the Schema in one position and her Healthy Adult, originally played by me, in the other position. She was able to authentically conclude that she was willing to try to address this trigger event as an opportunity to address this Schema and to cultivate her sense of autonomy. This decision itself was an act of strengthening her innate desire for autonomy. As with Steve, I experientially guided her to feel the anguish of her "dependent little child," to validate her feelings, and to help her understand why she was plunged into such intense anxiety and confusion. I invited her to work with me to encourage and gently guide her Vulnerable Child to accept that this situation, although dreadful, was an opportunity to cultivate agency and competence.



We talked through what she needed in order to feel more in control over this situation. I suggested as homework assignments that she learn more of what were the best guidelines for safety during the pandemic and asked her to report back to me what she learned. I also suggested ways she could be of service to some of her friends to balance the ways in which she imposed upon her friends for support and reassurance. I suggested creating a new routine for her days that we would discuss together. And we collaborated together to fight against the Compliant Surrender Mode, her default Mode, and to determine ways to shift back to her Healthy Adult Mode that was more invested in taking charge of her life and not giving in to the powerful pull of her Dependency/ Incompetence Schema. In the process, she found new depth in some of her most important relationships and a sense of power in herself that seemed so elusive in the past.

Although these two examples reflect Schema activation triggering a Compliant Surrender Mode, other Modes can also be activated that serve as an overlay to a core Schema related to undermined autonomy. For instance, an Overcompensator Mode could be a way of understanding the way some people have defied informed scientific recommendations. Some of these people who refuse to wear masks may have an impaired autonomy related Schema while acting as if they are exercising their right to choose. Sometimes this is not authentically autonomous behavior but a Mode reaction to and perpetuation of a Dependency or Enmeshment Schema.

Autonomy can seem like an impossible need to provide and help fortify when the ability to choose seems more limited than ever. While the powerful Schemas that were built on this unmet need can flourish at a time like this, there is also a possibility for change and healing. It starts with an understanding of what is being activated and why. Focused attention to the Vulnerable Child with empathy and validation must take precedence, followed by the work of weakening the Modes that perpetuate such Schemas as Enmeshment and Dependency. Throughout this process, it is essential to engage in strengthening the Healthy Adult that is invested in fostering personal autonomy and agency while still valuing and considering the feelings and needs of oneself and others. This kind of therapeutic work can pave the way for taking this highly disruptive and Schema activating event and transforming it into an opportunity to gain a stronger sense of personal agency and to cultivate and maintain more realistic and connected relationships.

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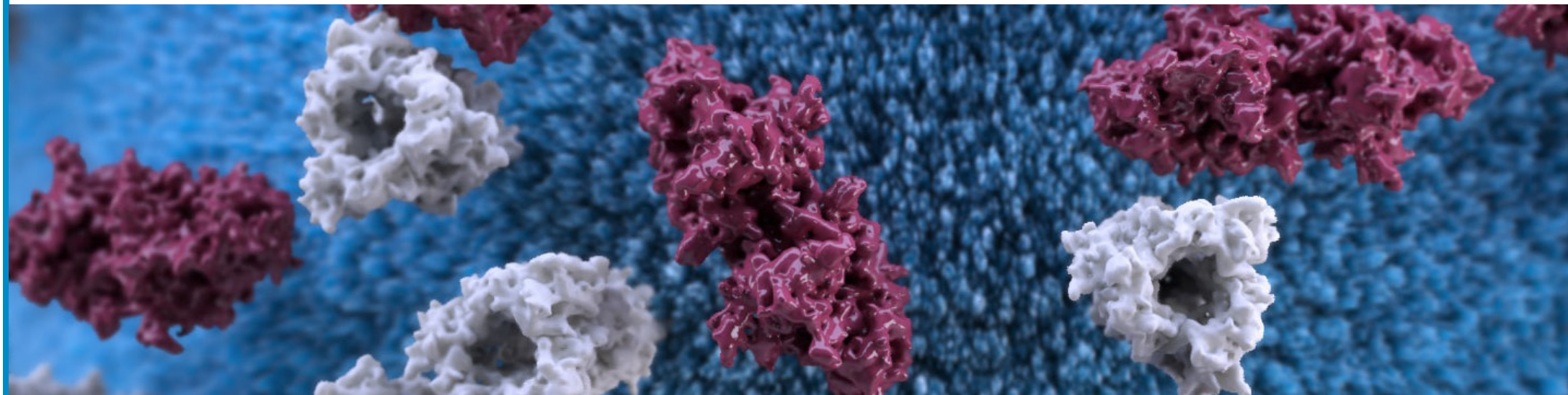
THE EFFECTS OF COVID-19 QUARANTINE
ON THE THERAPEUTIC PROCESS & TREATMENT OF CLUSTER C PATIENTS

INTRODUCTION

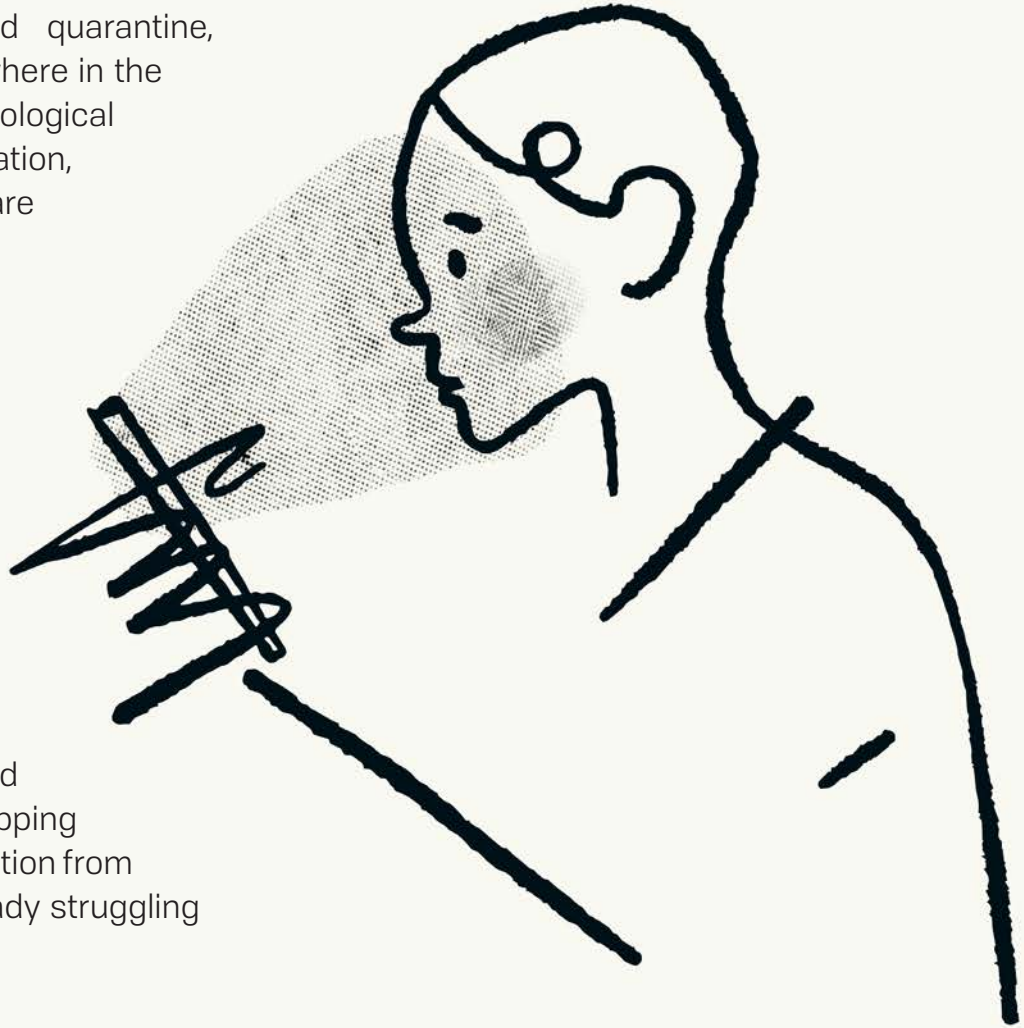
As scientific research efforts about the COVID-19 pandemic continue, there is an increasing amount of information about its short- and long-term effects. Researchers from all over the world have focused their attention on exploring and understanding not only the immediate concerns associated with the virus, but also its impact on the day-to-day lived experiences of everyone in its wake. Some studies resulting from these efforts have revealed the real and potential consequences of the pandemic on mental health. Despite this new data and some studies on the effects on those with Borderline Personality Disorder (BPD), there is still lacking research on the influence of COVID-19 on individuals diagnosed with Cluster C traits and personality disorders (PD).

In this article we will focus on the influence quarantine has had on this population through a Schema Therapy (ST) lens. We will touch on literature related to the influence of the quarantine and its duration on people in the general population while also considering associated effects on patients with Cluster C traits or PD, therapists working with them, and therapeutic relationships share. After addressing this literature and reflecting on our professional experiences through case examples, we will present our thoughts on mitigating the effects of extended isolation on Cluster C patients during the COVID-19 pandemic.



THE EFFECTS OF QUARANTINE AND EXTENDED ISOLATION ON MENTAL HEALTH AND RELATIONSHIPS

We know that in order to reduce the spread of the virus, national and international institutions have ordered quarantine, social distancing, and isolation almost everywhere in the world. There is evidence to suggest the psychological consequences of quarantine, such as frustration, loneliness, and worries about the future are well-known risk factors for several mental disorders, including anxiety, affective disorders, and psychoses (Giallonardo, et al., 2020). Moreover, objective social isolation and subjective feelings of loneliness are associated with a higher risk of suicidal ideation and suicide attempts (Giallonardo, et al., 2020). Recent findings support the primary hypothesis that the prevalence of probable moderate to severe depression, suicidal ideation, self-harm, and emotional distress because of COVID-19 was significantly higher among quarantined than non-quarantined participants (Xin, 2020). Given these overlapping factors, we can conclude that extended separation from others will be a difficult burden for those already struggling with Cluster C traits.



There is already some data about the immediate concerns for patients with BPD. Public health measures during the COVID-19 outbreak, such as social distancing and mass indoor quarantine, could intensify their feelings of emptiness and aggravate fears of abandonment among people with BPD, coupled with other distressing emotions (Chong., 2020). While Chong (2020) presses that further empirical studies are needed to investigate the functioning and responses of people with BPD during this pandemic, we feel these empirical efforts should also focus on patients with Cluster C traits and PD.

We know from previous findings that these issues are not unique to the COVID-19 pandemic. Three studies showed longer durations of quarantine were associated with poorer mental health. Specifically, the subjects of these studies maintained a higher prevalence of post-traumatic stress symptoms (Hawryluck, 2004), avoidance behaviors (Reynolds, 2008), and anger. Although the duration of the quarantine was not always clear, one study (Hawryluck, 2004) showed that those quarantined for more than 10 days manifested significantly higher post-traumatic stress symptoms than those quarantined for less than 10 days.

We can anticipate that the effects of extended isolation on those with Cluster C traits or PD will last long after COVID-19 has been contained. One study (Jeong, 2016) compared psychological outcomes during quarantine with later outcomes and found that during a national quarantine for SARS in China, 7% (126 of 1656) showed anxiety symptoms and 17% (275) showed feelings of anger, whereas 4–6 months after quarantine these symptoms had reduced to 3% (anxiety) and 6% (anger). After quarantine, many participants continued to engage in avoidance behaviours. A study of people quarantined because of potential viral contact noted that 54% (524 of 1057) of people who had been quarantined avoided people with symptoms, 26% (255) avoided crowded enclosed places, and2 1 % (204) avoided all public spaces in the weeks following the quarantine period. A qualitative study reported that several participants described long-term behavioral changes after the quarantine period, such as vigilant handwashing and avoidance of crowds and, for some, the return to normality was delayed by many months. These results can be related to the Cluster C patients, who have one of the most prominent problems among these findings: Avoidant or Overcontroller coping modes, which can become stronger during the quarantine.

Extended isolation or quarantine affects interpersonal relationships

Extended isolation or quarantine affects interpersonal relationships, perhaps even more so for those with Cluster C traits or PD. Quarantine can create family dependencies, threaten livelihoods and lead to the stigmatization of those infected (Brooks, 2020). Additionally, elevated psychological distress was negatively associated with relationship improvement for partnerships, but positively associated with improvement in relationships with friends and community (Xin, 2020). Family dependencies could be a good way to survive in stressful life conditions; but, at the same time, this pattern is so comfortable and familiar for Cluster C patients that it could amplify their problem, perpetuate their schemas, and prevent them from fully meeting their needs.

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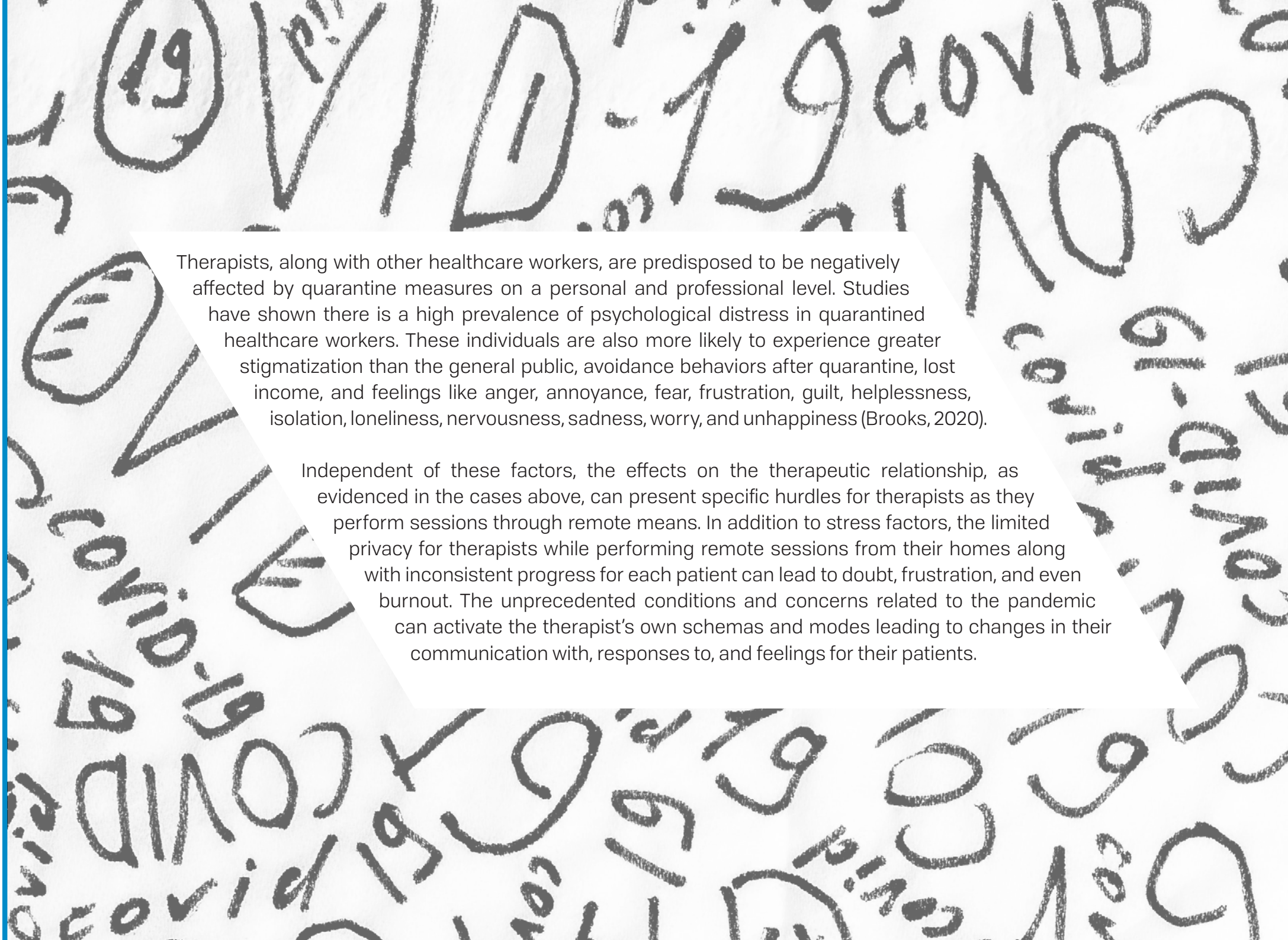
INFLUENCE OF QUARANTINE ON THE THERAPIST

In the following section, we will discuss the influence of quarantine on patients and the therapeutic relationship, but it is important to take the therapist's well-being into account as therapy is a collaborative process. The COVID-19 pandemic presents unique setbacks, relapses, and challenges within each therapy session that can have material and emotional consequences for therapists that are caused while providing care.



Therapists, along with other healthcare workers, are predisposed to be negatively affected by quarantine measures on a personal and professional level. Studies have shown there is a high prevalence of psychological distress in quarantined healthcare workers. These individuals are also more likely to experience greater stigmatization than the general public, avoidance behaviors after quarantine, lost income, and feelings like anger, annoyance, fear, frustration, guilt, helplessness, isolation, loneliness, nervousness, sadness, worry, and unhappiness (Brooks, 2020).

Independent of these factors, the effects on the therapeutic relationship, as evidenced in the cases above, can present specific hurdles for therapists as they perform sessions through remote means. In addition to stress factors, the limited privacy for therapists while performing remote sessions from their homes along with inconsistent progress for each patient can lead to doubt, frustration, and even burnout. The unprecedented conditions and concerns related to the pandemic can activate the therapist's own schemas and modes leading to changes in their communication with, responses to, and feelings for their patients.

THE THERAPEUTIC RELATIONSHIP WITH CLUSTER C PATIENTS DURING QUARANTINE

Through the ST approach we know that a Cluster C patient's coping modes are very strong and rigid. A lot of attention is paid in ST therapy to bypassing the Perfectionistic-Overcontroller and Avoidant coping modes in order to help patients connect with their Child modes. During the pandemic we observed the influence COVID-19 related lockdowns were having on our Cluster C patients and our therapeutic relationships. In this section we will describe these consequences in greater detail and reflect on three case examples for each PD of Cluster C.

Across the following three cases, we noticed that the therapeutic relationship can change due to the stressful conditions incubated by quarantine. Concerns about their personal safety and contracting the virus evokes more anxiety and fear in these patients, which leads them to rely on their coping mechanisms even more and, as a matter of course, can weaken the connection they have with their therapist. While this set of behaviors can be expected in Avoidant PD and Obsessive-Compulsive PD patients, Dependent PD patients may manifest their patterns differently. Those with Dependent PD could become even more compliant and surrender to the therapist, blocking their need for autonomy and causing them to request more contact in and outside sessions. Regardless of these patients' varied responses, therapists and patients need to contend with therapeutic challenges unique to the COVID-19 crisis.

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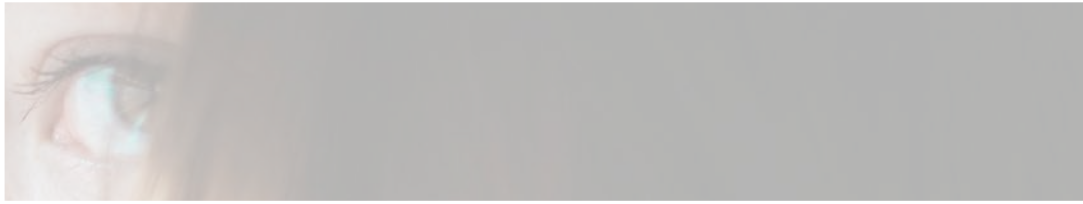
The pandemic and lockdown appeared to strengthen the Perfectionist-Overcontroller mode in many patients. One patient (Z.) with Obsessive-Compulsive PD (OCPD) had already completed a lot of work to bypass the Perfectionistic-Overcontroller mode before social isolation. Specifically, in February 2020 she underwent chair work focused on differentiating her Overcontroller and Healthy Adult modes. Her Overcontroller mode made her feel she should be wary of the "new Chinese virus" and international travel. Her Healthy Adult mode let her conclude that "she should live a fulfilling life and travel when it's possible and the risk is low." She travelled to Italy and had big difficulties returning. As a result, her Overcontroller mode was strengthened. It became very hard for her to bypass the Overcontroller mode while it was getting a lot of reinforcement from news and WHO guidelines. She was following all restrictions closely and went back to "living in a shell." By the time her sessions resumed, they were no longer in person, but online instead. Between the strengthening of her Overcontroller mode due to outside stressors and the challenges of adapting the therapeutic relationship to online sessions, her progress reverted back to almost the beginning of therapy and she had difficulty accessing her Vulnerable Child mode.

The uncertainty of the COVID-19 pandemic has made it harder to reinforce Healthy Adult modes. In Z.'s case, the fact her Overcontroller mode was right and her Healthy Adult mode was wrong could have caused her to mistrust the therapist and the therapeutic relationship. From the therapist's part, however, it could have stirred up feelings of uncertainty and guilt in him/her as the patient regressed to trusting old patterns.

For patients with Dependent PD, lockdown has negatively impacted their Self-Sacrifice and Enmeshment schemas and activated their Compliant-Surrender mode. One 30+ year old patient (A.) who is a single mother with emotional dependency had been in therapy for 10 months before the lockdown and was able to recognize Guilt-Inducing/Enmeshed Parent mode and confront it. She learned to stay in Healthy Adult mode, protect her boundaries, and not rely on her Compliant-Surrender mode. When the pandemic started, she felt extreme responsibility for her parents and decided to spend lockdown with them even though one of her therapeutic goals over the previous 6 months was to separate herself and live alone with her child. When she moved back in with her parents she returned to her old patterns. Since she was afraid her parents were vulnerable to COVID-19 and believed herself to be the only person who could protect them, she began to take sole control over their wellbeing. As she was getting more involved in her parents' life she started to feel guilty taking care of her own needs as her Guilt-Inducing/Enmeshed Parent and Compliant-Surrender modes intensified.

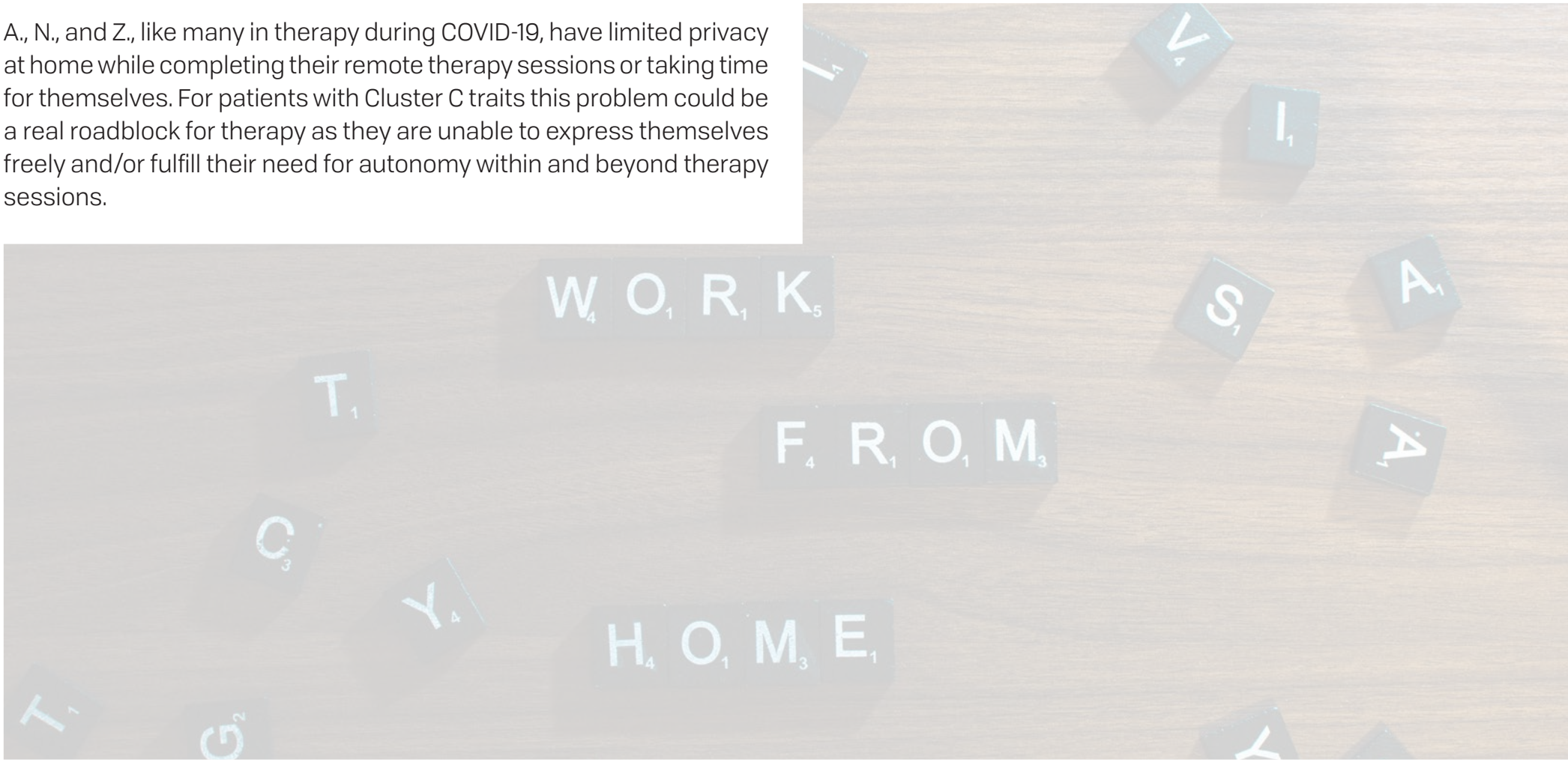


In this circumstance, COVID-19 related regressions could evoke frustration and guilt in both a patient with Dependent PD and the therapist treating him/her. Given the material progress A. achieved by moving out of her parents' home, her choice to move back in with them could disrupt communication between herself and her therapist as the therapist reckons with feelings of anger and disappointment. In turn, the patient could either withdraw completely or enter the Compliant-Surrender mode within the therapeutic relationship.

Social isolation can validate avoidant traits in individuals who have struggled in environments where their avoidance was aberrant or unwelcome. One patient (N.) who is a 30+ year old married woman with Avoidant PD stated that, because of COVID-19 lockdown measures, "I finally feel that I'm normal or all other people are as crazy as I am." Even before the mandated lockdown N. decided to isolate herself and convinced her husband to do the same out of fear that she would contract the virus. At the beginning she felt good, claiming she was "doing the right thing," but no one left their house once in a four month period of time. So long as her choice to not leave her home continues to be supported by safety recommendations and measures, N.s' Avoidant-Protector mode will be strengthened and unchecked with no end in sight.

As is the case for the other PDs presented in this section, the therapist is consistently put in the position to wager whether they should validate safe choices or enable previous negative behaviors in patients. The therapeutic progress and, by extension, the therapeutic relationship could be stalled for patients like N. and their therapists. Each therapeutic session impacted by COVID-19 regulations may stir up feelings of frustration and anger in both patient and therapist because progress made before lockdown had been thwarted and healthy alternative treatment options may go against safety protocols.

A., N., and Z., like many in therapy during COVID-19, have limited privacy at home while completing their remote therapy sessions or taking time for themselves. For patients with Cluster C traits this problem could be a real roadblock for therapy as they are unable to express themselves freely and/or fulfill their need for autonomy within and beyond therapy sessions.



MITIGATING THE EFFECTS OF THE COVID-19 PANDEMIC ON CLUSTER C PATIENTS

The pandemic causes many patients to share fears and anxieties about working towards agreed upon goals that were defined before the onset of social isolation mandates. Taking the aforementioned case examples and risk factors for patients with Cluster C traits and their therapists into account, we are presenting the following recommendations to meet the strains and intricacies of providing therapeutic care during the COVID-19 crisis.

Provide as much information as possible. Because extended isolation and fear of infection can exacerbate Cluster C traits and PD, the therapist should work with patients with these diagnoses to determine how the pandemic affects their specific situations. It should be a priority to make sure patients have a good understanding of COVID-19 and the reasons for quarantine.

Be flexible. As life evolves alongside changes resulting from the spread of COVID-19, therapists and patients should be prepared to adapt their plans and goals. By prioritizing flexibility and resiliency, the therapist can leverage the uncertainty of the pandemic to strengthen and augment a patient's Healthy Adult mode.

Emphasize personal growth. Ask the patient "do you think one year ago that you would have thought you would be able to manage with as many struggles as you have during the pandemic?" In doing so, you give the patient the opportunity to become aware of the positive advancements they have made despite limiting factors.

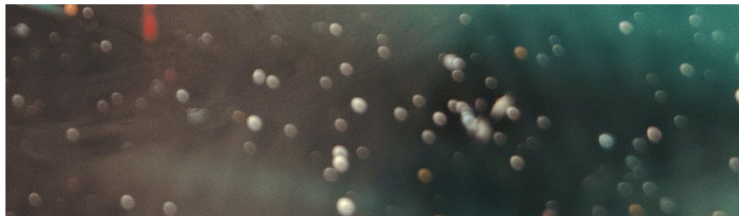
Encourage connection with others. In order to manage compounding stress factors for Cluster C patients due to extended isolation, recommend or organize support groups where they can have their experiences and feelings related to the pandemic validated.

Develop a timeline for returning to normal life. While it remains unclear when COVID-19 protocols and mandates will end, identify what each patient thinks he/she will need to have or know before they feel safe from infection and isolation.

Maintain self-awareness. Therapists affected by the spread of COVID-19 can anticipate increased stress factors and decreased patient progress. Take the time to evaluate the activation of your own schemas and modes before they impact the quality of care you can provide.

Remember your own needs. Treating Cluster C patients during this difficult time can make it harder for therapists to find spaces and practices for their own mental wellbeing. Work in a team, communicate with colleagues and peers, and speak with supervisors in order to develop positive and safe social activities. Use your personal time to pursue physical and creative activities, as well.

Stay focused. Regardless of negative feelings and experiences, it is essential to keep patients with Cluster C traits or PD on track for overcoming dysfunctional patterns exacerbated by the pandemic.



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USING VIDEO FEEDBACK FOR STRENGTHENING HEALTHY ADULT MODE AND ENHANCING MODE WORK

VIDEO FEEDBACK
Schema therapy tecnique

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WHAT DO WE DO?

- Make video recording of sessions
- Analyze and share the information or look together with the client through and during the session
- The client analyzes the video as a homework task

WHY?

- To improve self-awareness
- To improve self-reflection
- To improve mentalization
- Good outcomes

USING VIDEO FEEDBACK FOR STRENGTHENING HEALTHY ADULT MODE AND ENHANCING MODE WORK

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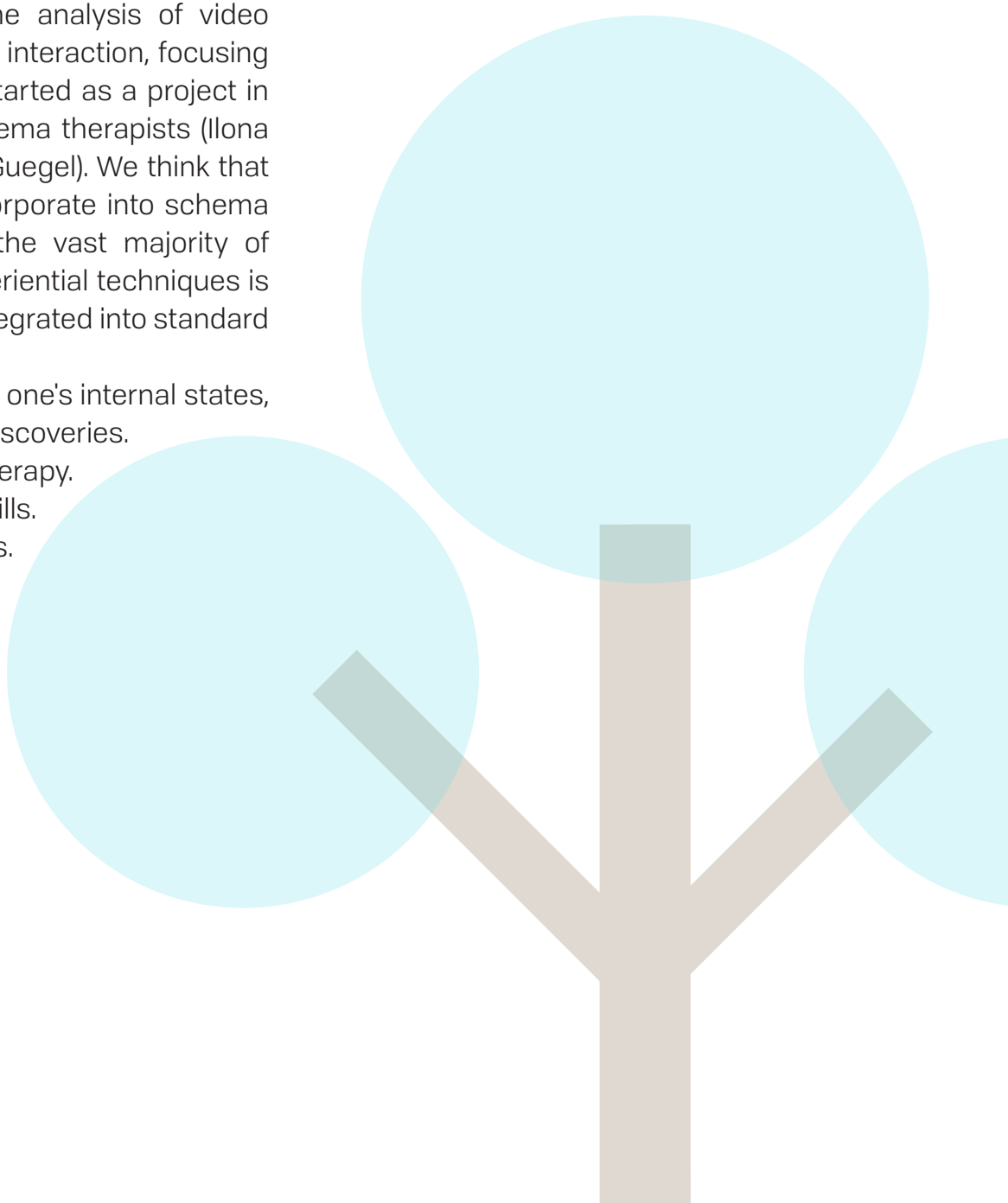
Using video recordings in the therapy process was initiated as part of Dr. Krone's doctoral research (Krone, 2009 - 2012), which included the analysis of video material in the context of child development and parent-child interaction, focusing on maternal reactions. Video feedback in Schema Therapy started as a project in 2018 with a collaboration between Latvian and Russian Schema therapists (Ilona Krone, Alexandra Yaltonskaya, Darya Maryasova and Natalia Guegel). We think that this approach can be particularly beneficial and easy to incorporate into schema therapists' practice during the COVID-19 pandemic when the vast majority of consultations take place on-line and the use of standard experiential techniques is somewhat limited. However, this protocol can also be easily integrated into standard in-person sessions of schema therapy.

Self-awareness, in the sense of an ongoing attention to one's internal states, is considered the basis for psychological insight and new discoveries. Along with self-reflection, it is an important goal in psychotherapy. Many therapies focus on the ability to strengthen these skills. Studies have shown that empathy builds upon self-awareness. The more open we are to our own emotions, the more skilled we will become in reading and identifying our feelings. Individuals with greater certainty about their feelings and reactions can be better pilots for their lives (Goleman, 1996).



From a neuropsychological perspective, self-awareness seems to require an activated neocortex, particularly in language areas. This helps to identify the emotions being aroused (Goleman, 1996). Another theory is that self-awareness arises from the interaction between processes in multiple parts of the brain, especially the prefrontal cortex and the inferior parietal lobule, where the right hemisphere plays a prominent role (Keenan, Gallup, & Falk, 2003). The awareness of emotions allows for the regulation of various emotional states, which is a fundamental component of developing emotional self-control and is an element of emotional intelligence. The client learns to become a good parent for themselves, to help regulate and manage emotions in order to achieve goals that are important to them. It has been established that impulse control requires the ability to differentiate between emotions and behavior, make decisions based on meeting emotional needs, and respond in a new and alternative manner, with an awareness of consequences. Self-awareness also takes the form of recognizing strengths and weaknesses, and seeing the self in a positive but realistic light (Goleman, 1996).

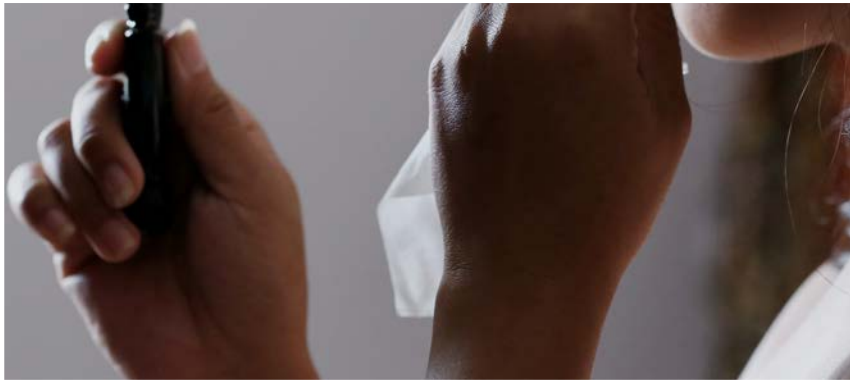
While developing self-awareness, Schon (1983, 1987) identified two types of self-reflection[1]:

reflection-in-action (i.e., spontaneously processing what you are doing while you are doing it)

reflection-on-action (i.e., processing events after they occur).

The use of video feedback focuses on reflection after an experience. It is a process that allows for the client's reevaluation of an experience:

(a) returning to an experience (i.e., recalling the experience)
(b) exploring feelings associated with an experience
(c) reevaluating an experience in light of a new affective awareness
(Boud, Keogh, and Walker , 1985)



[1]The cyclical process where individuals engage in a critical evaluation of their affective, cognitive, and behavioural experiences, and through dialogue and generalization, produce insight and fundamental shifts in their original assumptions and beliefs (Brockbank & McGill, 1998; Dewey, 1933, 1944; Goodyear, 2005; Kolb, 1984; Schon, 1983, 1987 cited in Orchowski, Evangelista & Probst, 2010).

This process can be implemented using the following steps (see Figure1):

1. Select - Identify and select the issue or situation requiring reflection.
2. Describe - Describe the reactions, meanings, circumstances or other issues related to the topic that has been selected.
3. Analyze - The process of reflection. This includes what might be called analysis and evaluation and "digging deeper". This step explores emotional needs, emotions themselves, thoughts and other levels of inner reality. The question could take the form of, 'why?' and 'how?'.
4. Appraise - to evaluate the appropriateness and impact of reactions.
5. Transform - to shift from analysis and reflection into action. What changes can be made to your reactions?

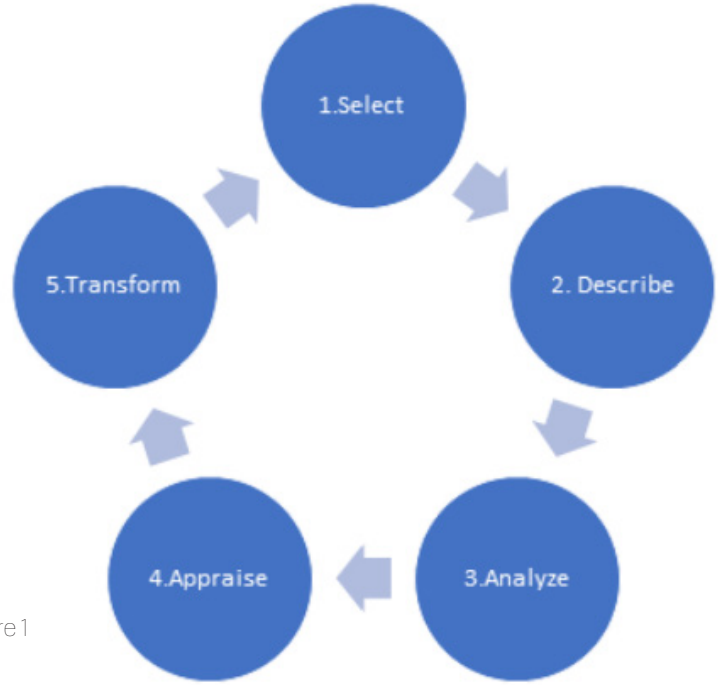
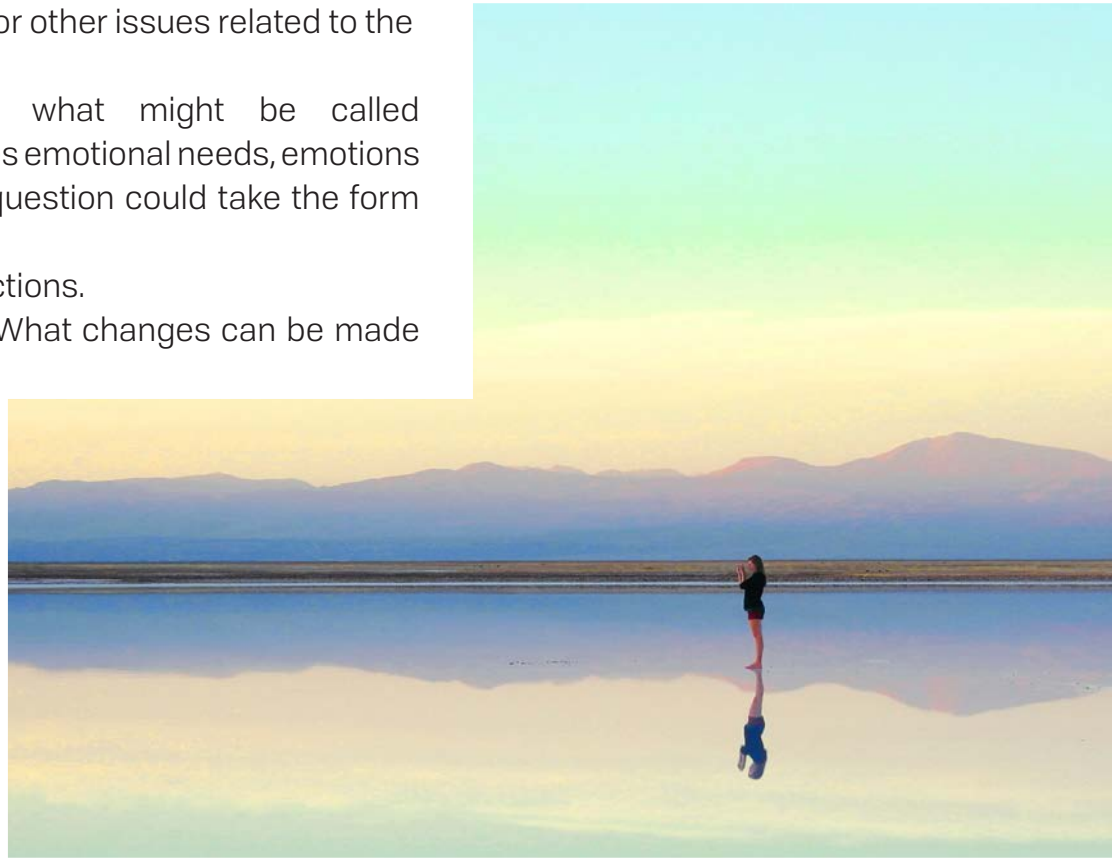


Figure 1



To complete this self-reflection process, worksheets are used as part of the Video Feedback approach as an important process of reflective writing that is more than simply a description of self-observations or thoughts. Reflective writing encourages clients to see situations from all angles (Self-Assessment , 2006,[11].

Why use video in client sessions at all? There are several possible answers, one of which can be understood from a neuropsychological perspective. Research suggests that what we see is influenced by what we remember and feel, so asking clients to describe what they are seeing helps the person to slow down and assign a new meaning to the event in question (Kalat, 2004) Another important benefit from watching a video is an ability to recognize emotions from facial and body expressions. This is crucial to adapting one's social behaviors. The watching of one's own face and watching the faces of others involves completely different parts of the brain and helps in self-reflection (Ryan, Stolier & Freeman, 2016). There is also support for the idea that therapeutic interplays of processing external and internal visual stimuli helps the client in the process of changing. In turn, as ventral neurochemical reward circuits engage and expertise, identification with self-generated objects, feelings of ownership and degrees of mastery and control creation trigger a sense of achievement (Hass-Cohen & Carr, 2008).

On a second order of change, there are more enduring meta-meanings of mastery and control from going back and forth between internal and external images and balancing familiar and novel stimuli. As ventral pathways engage, clients' memories trigger, stabilize, and/or change during therapeutic interplays of external and internal visual stimuli processing. Autobiographical meaning-making is mediated by visual processing suggesting that, "What I see is coherent with who my memories tell me that I am" (Hass-Cohen & Carr, 2008 ;Absher & Cloutier, 2016). So, we can assume that video feedback and self-awareness is helpful to changing the perceptions of oneself. Visual information processing can answer, "How do I feel about what I see and what do I do about it? How will what I do reward me, and will I want to do more?". There is additional theoretical support on the neurobiological level, that reflecting upon ourselves, encoding and retrieving information about ourselves is what we need in therapy (Absher & Cloutier, 2016).

Using video recordings, it is possible to show the episodes that the therapist wants to analyze in more detail, to help the client understand their reactions, or to reinforce the desired reactions of a Healthy Adult or a Happy Child. Through this approach, clients also practice mindful awareness by focusing on current experiences and learning a non-judgmental and accepting attitude toward their own experiences (Bishop et al., 2004). Mindful observation from the side-lines not only enhances self-awareness but is also important in the mentalization process. It is known that a caregiver's ability to mentalize contributes to the formation of a secure attachment (Fonagy et al., 1996), which is likely important for strengthening a Healthy Adult.

There are several advantages to using video material:

1. The essence of video feedback is from the outside looking in. "Movies and pictures have been shown to affect the viewer differently than spoken words. The sight modality to address parts of emotional engagement." (Vik & Rohde, 2012)

In turn, it is important for the therapist to act on several levels during the film review.

(a) Be aware of the footage and what is happening on-screen.

(b) Be able to observe clients during a session and be sensitive to client cues, reactions, and needs.

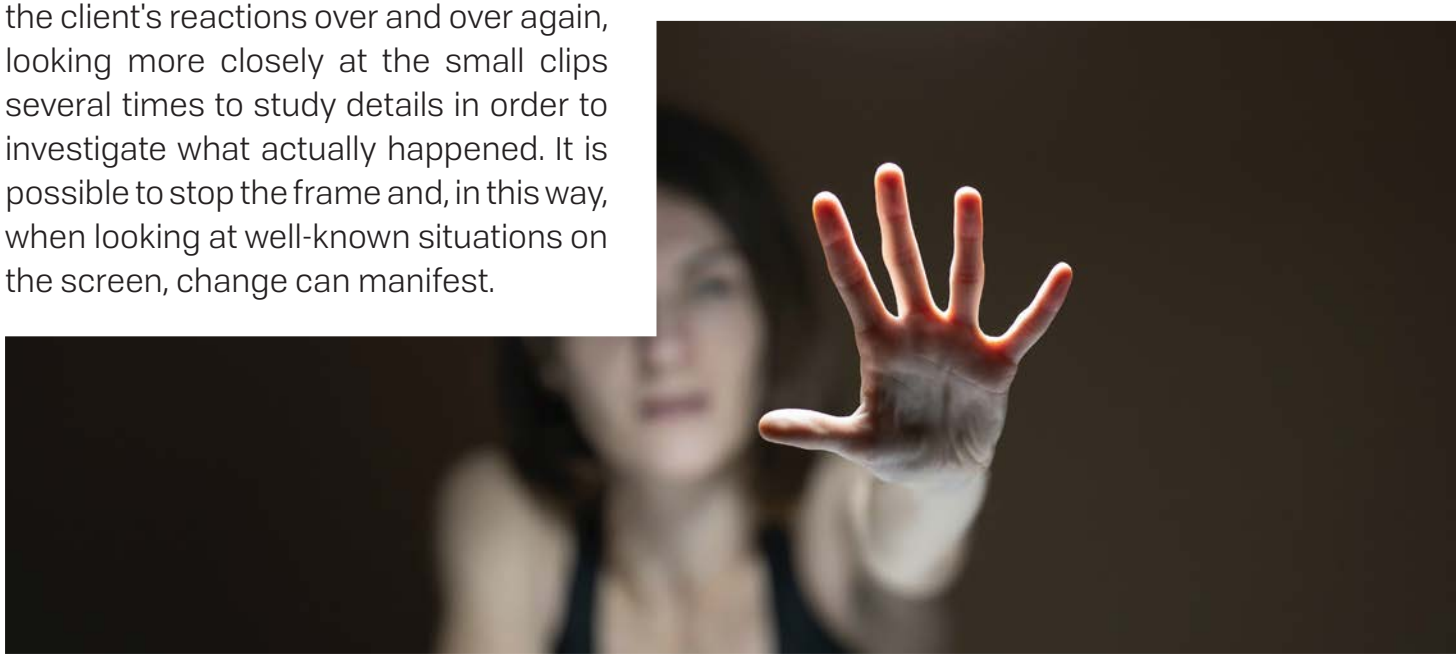
(c) The therapist should also be able to observe the client's emotional reactions, validate, and name them.

(d) To notice related body reactions and help to integrate them.

(e) If or when the client discovers something important, provide the opportunity to create new thoughts, feelings, and a new vision.

"All together the review sessions are a complex interplay between human resources and technical devices." (Vik & Rohde, 2012)

2. Events are the subjective experience of 'real' events. The images on the screen are from "real life", which allows you to more accurately identify what really happened and thus adjust or change representations of what happened.
3. Micro events: In the film we can observe small non-verbal movements, including the direction of the eyes, but also hear the tone of the voice during the interaction.
4. Repeat the event/reaction.
Stern (1998) states that it is the repetitiveness of events that makes them easily represented. It is possible to see the client's reactions over and over again, looking more closely at the small clips several times to study details in order to investigate what actually happened. It is possible to stop the frame and, in this way, when looking at well-known situations on the screen, change can manifest.



Changes can occur on several levels: cognitive, behavioral, and emotional. Cognitively, a new perspective can emerge and new ideas can be generated on how to react the next time when a similar situation arises. In the same way, changes could be made at the behavioral and practical levels, increasing the repertoire of adaptive behaviors. Emotional level - the ability to recognize and accept different emotions, experience them by watching video material and receive therapist validation (Vik, 2010). In this way repetitive micro events, displayed on the TV screen, can change mental representations like feelings of insufficiency.
The repetition itself could be the starting point for building generalized models of events and new representations. Changes in ways of thinking and feeling comes, 'from the outside looking in'-perspective (Vik, 2010) and the alternate way of acting will manifest in real life through action. "In the next session`s film, it is possible to observe and confirm a new schema." (Vik & Rohde , 2012).

Ilona Krone, Alexandra Yaltonskaya, Darya Maryasova

In order to help strengthen Healthy Adult mode, or to enhance work with all other modes through video feedback in Schema Therapy practice, we developed a structured step-by-step approach: "Seeing is believing". This approach uses video recording of on-line or off-line sessions of schema therapy for further analysis by the therapist and client together, or individually by client or therapist. We believe that observing and analyzing spontaneous emotional work that happens during therapy sessions can be exceptionally beneficial for increasing mode awareness and facilitate further emotional and behavioral changes. The role of the observer and the so-called "researcher" that are offered to a client in this approach can activate the Healthy Adult and motivate clients to take a more active role in the therapeutic process. This work can be added to standard schema-therapy practice when it is necessary and broaden the range of experiential techniques. It can also add novelty, creativity and make in-session work more technological in a way that can be more interesting and inspiring for some therapists, rather than the non-technological approaches.
"Seeing is believing", suggest following this systematic approach:

Step 1.
Therapist records one or two random sessions

Step 2.
Based on current therapy phase, goal of therapy or current therapy difficulties therapist choses techniques from suggested list.

Step 3.
Discussing the result of this work in-session and fill in feedback forms for both the client and therapist.

These techniques help therapists and clients to build case conceptualizations and raise mode awareness, offer strategies for enhancing their Adult, Good Parent and Happy Child, and provide specific techniques enhancing confrontation with Critic modes and Coping modes. We also suggest a group of techniques that help patients to practice taking care of and soothing their Vulnerable Child. It can be very insightful when patients see themselves in such states through videos where the natural desire to express self-compassion may take place as a result. In addition, we suggest using video-recording for identifying difficulties in therapeutic relationships. In order to understand more clearly what we suggest, we would like to give a few examples of these techniques. Feel free to use them and give us your feedback by (ilonakrone@gmail.com):

CONCEPTUALIZATION (THERAPIST):

- Therapist records three initial sessions.
- Therapist analyzes the video of these sessions at home and searches for mode expressions in the client. When a mode expression is observed, the therapist names the mode and notes the time of the video segment.
- Therapist analyzes cognitive distortions caused by schema in the client.
- When noticed, the therapist names the distortion and marks the time of the video segment.
- During session, modes and cognitive distortions are shown and discussed with the client and used for building conjoint conceptualizations.

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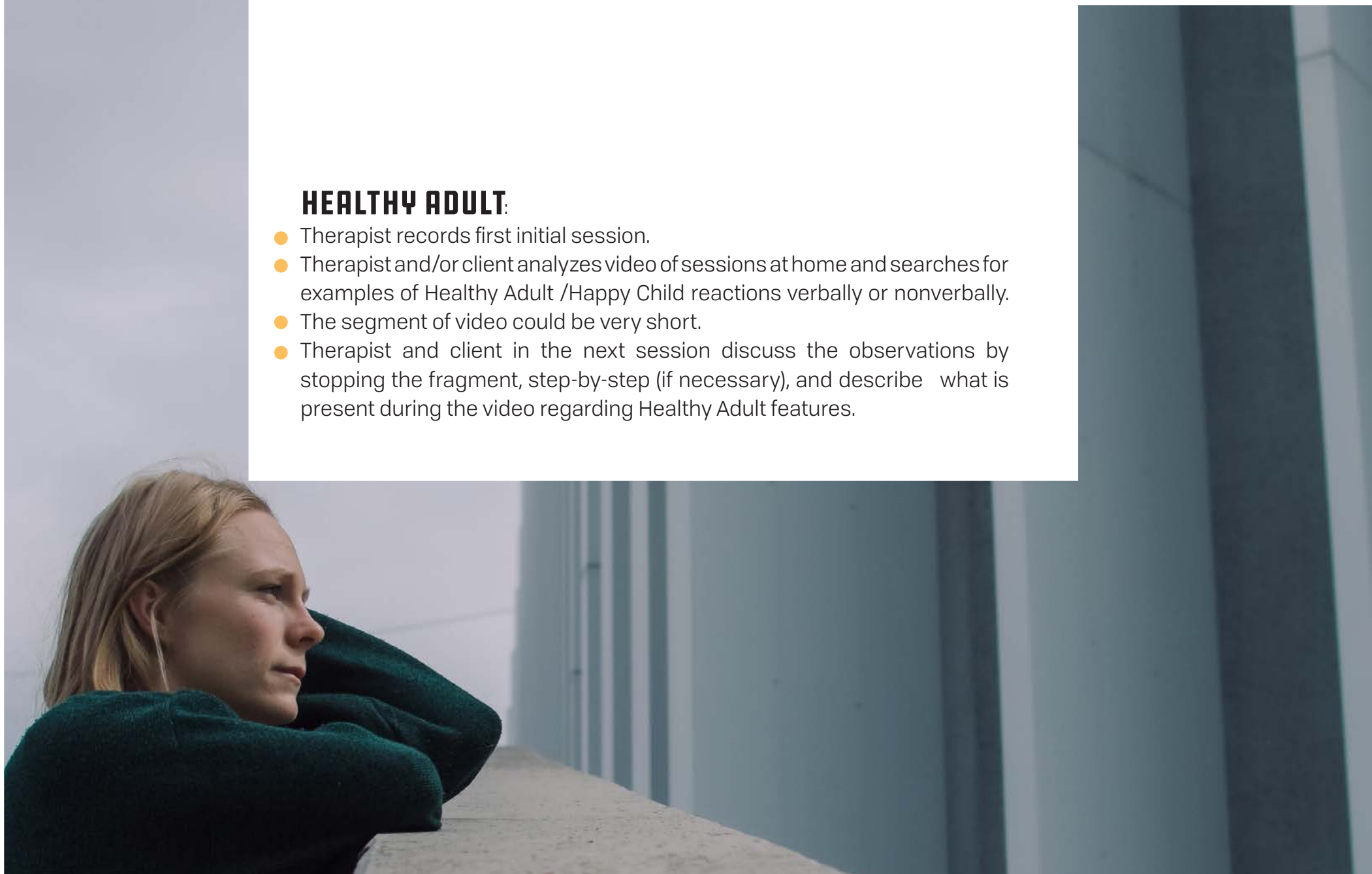
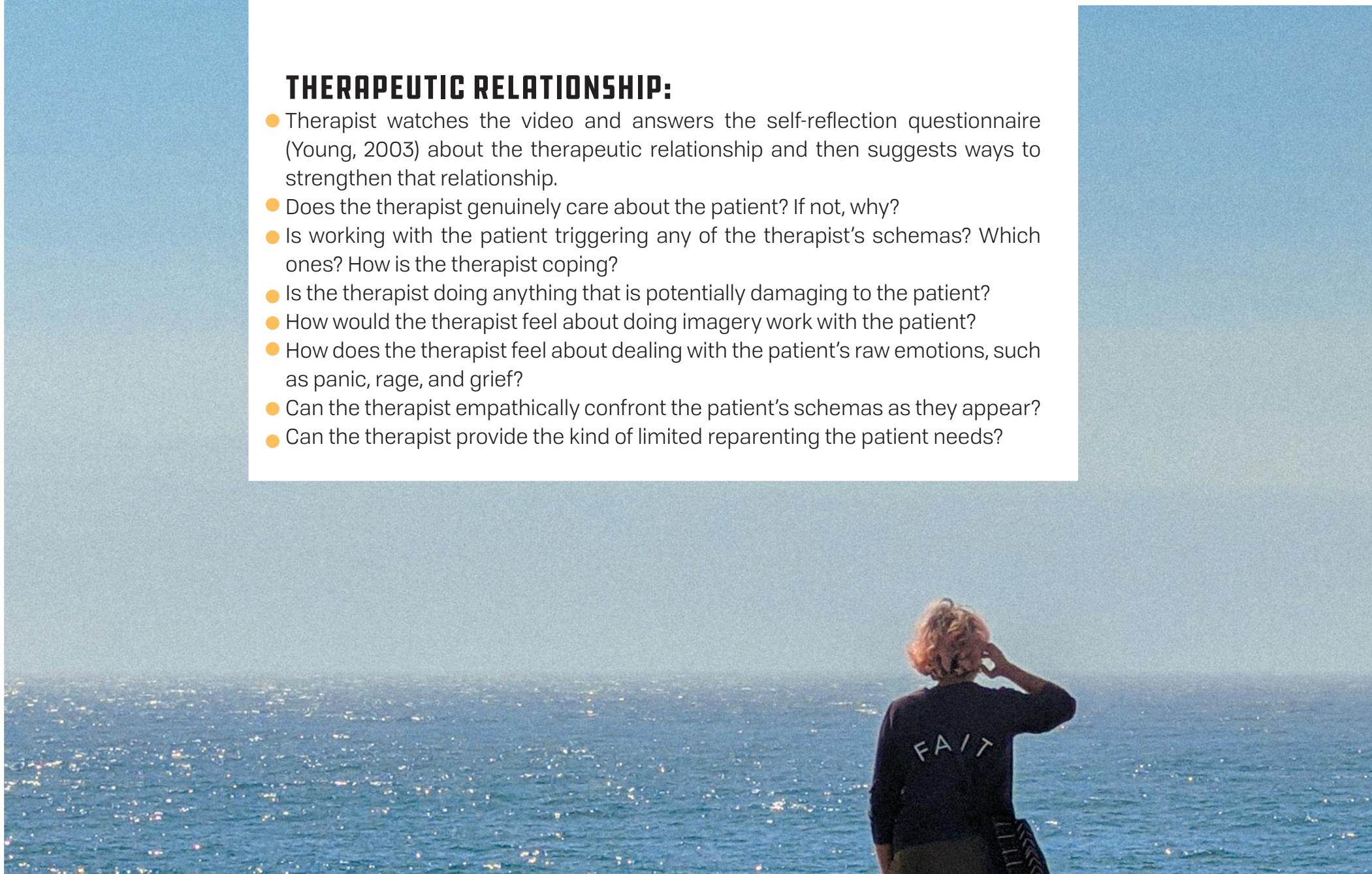
HEALTHY ADULT:

- Therapist records first initial session.
- Therapist and/or client analyzes video of sessions at home and searches for examples of Healthy Adult /Happy Child reactions verbally or nonverbally.
- The segment of video could be very short.
- Therapist and client in the next session discuss the observations by stopping the fragment, step-by-step (if necessary), and describe what is present during the video regarding Healthy Adult features.



THERAPEUTIC RELATIONSHIP:

- Therapist watches the video and answers the self-reflection questionnaire (Young, 2003) about the therapeutic relationship and then suggests ways to strengthen that relationship.
- Does the therapist genuinely care about the patient? If not, why?
- Is working with the patient triggering any of the therapist's schemas? Which ones? How is the therapist coping?
- Is the therapist doing anything that is potentially damaging to the patient?
- How would the therapist feel about doing imagery work with the patient?
- How does the therapist feel about dealing with the patient's raw emotions, such as panic, rage, and grief?
- Can the therapist empathically confront the patient's schemas as they appear?
- Can the therapist provide the kind of limited reparenting the patient needs?



We conducted a pilot study with six psychotherapists with at least 2 years of experience in the schema-therapeutic approach and obtained feedback from them and 10 of their clients.
Therapists considered it necessary to establish a therapeutic contact and create a safe therapeutic space, to conduct psychoeducation about the ST model, to make conceptualization and some classical experiential techniques before starting to work with video feedback. Clients mainly responded to the suggestion of video feedback techniques with some anxiety, embarrassment, and excitement, but also with interest and curiosity.
The advantages of the video feedback method were that it helps to:

- Strengthen and deepen the understanding of the ST model,
- Visualize the presentation of dysfunctional modes and learn to better recognize them and separate from them,
- Understand their triggers and the difference from healthy strategies (especially with regards to the difference between the Over-controller and Healthy Adult),
- Increase awareness in general,
- Build the connection with the vulnerable part and sensitivity to needs, activate and strengthen healthy modes and develop strategies of self-understanding, self-compassion and self-supporting more effectively,
- Better understand what is important for the client and what can be improved in the therapeutic relationships,
- Strengthen the connection through the revising of video recordings between sessions as a homework,
- Expand the range of experiential techniques and compensate for the lack of new emotional experiences while working online,
- Observe oneself from the outside and track changes,
- Return to important points, to notice and think about the processes, which are often out of sight,
- Promote more effective internal work between sessions,
- Trace the activation of therapists` schemas and modes ("self-supervision").

All therapists were ready to continue to use the video feedback method in the future and were tuned in to creatively modify these techniques to meet the needs of a particular client.
The main difficulties in using the video feedback techniques were related to the activation of clients' maladaptive schemas (primarily defectiveness and mistrust) and modes (primarily critical and avoidant), which could also be used as diagnostic material.
In conclusion we would like to invite schema therapists to try these ideas in practice and give their feedback via email to Dr. Ilona Krone (ilonakrone@gmail.com). Meanwhile we are going to continue working on structuring, "Seeing is Believing", in order to conduct an effectiveness study in the future that can help us to understand how effective this method can be.

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INTERVIEW WITH DR. ARNOUD ARNTZ

BY VIVIAN FRANCESCO

Can you tell us a little bit about yourself?

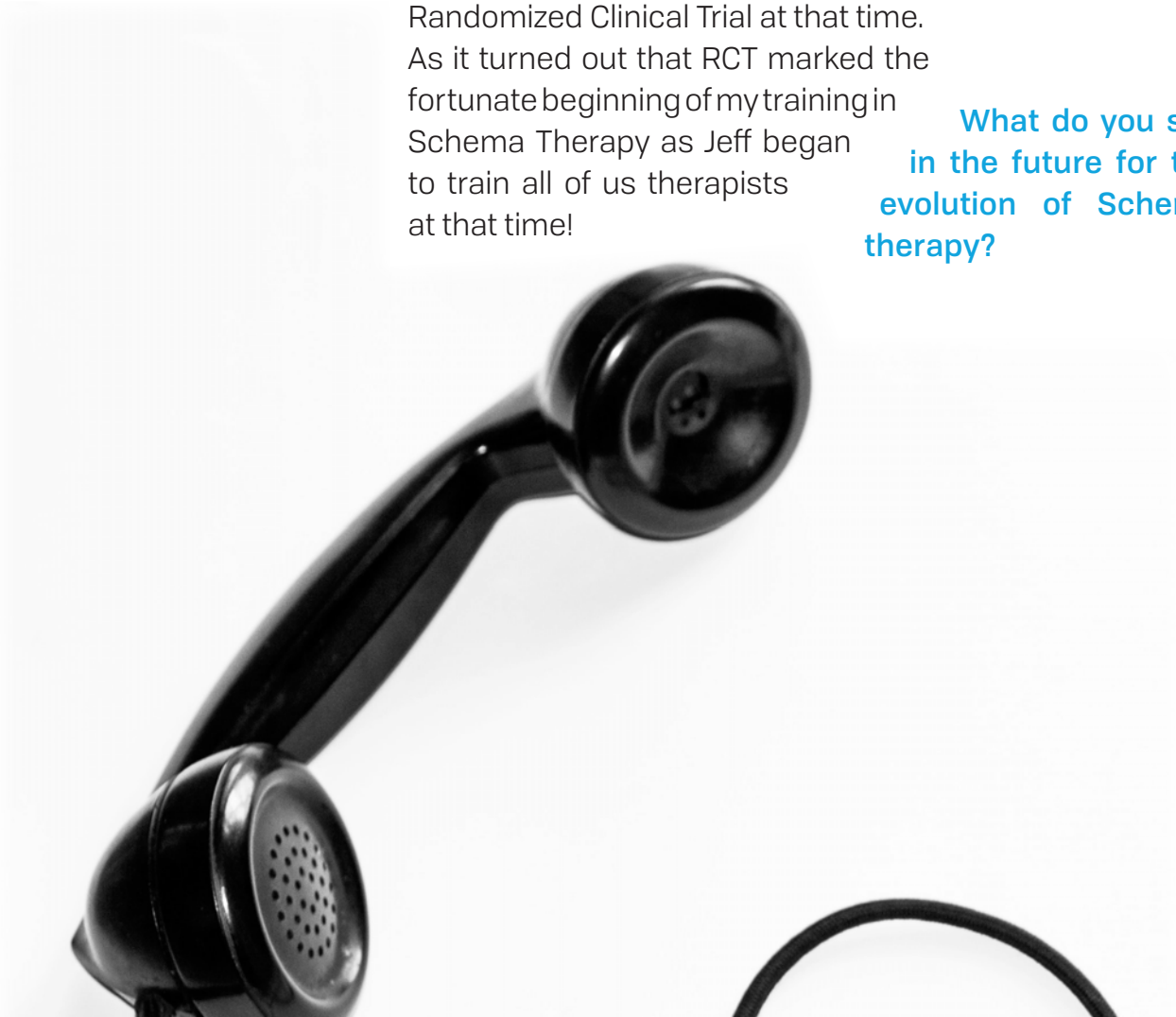
First of all, I am honored to have been offered a lifetime membership to the ISST on behalf of my extensive research in Schema therapy.

I was born in Utrecht in the Netherlands and I studied at the University of Groningen which is in the north of the Netherlands. I was happy to find a job at Maastricht University which is in the southeastern part of the Netherlands with a very distinct "flavor" all its own. In Maastricht a collaboration project was set up with the community mental health center which gave researchers the opportunity to participate in health care and do clinical research. Almost 6 years ago my wife and I moved to Amsterdam, so now I am back in the part of the Netherlands where I was born.

I have a beautiful daughter from my first marriage.

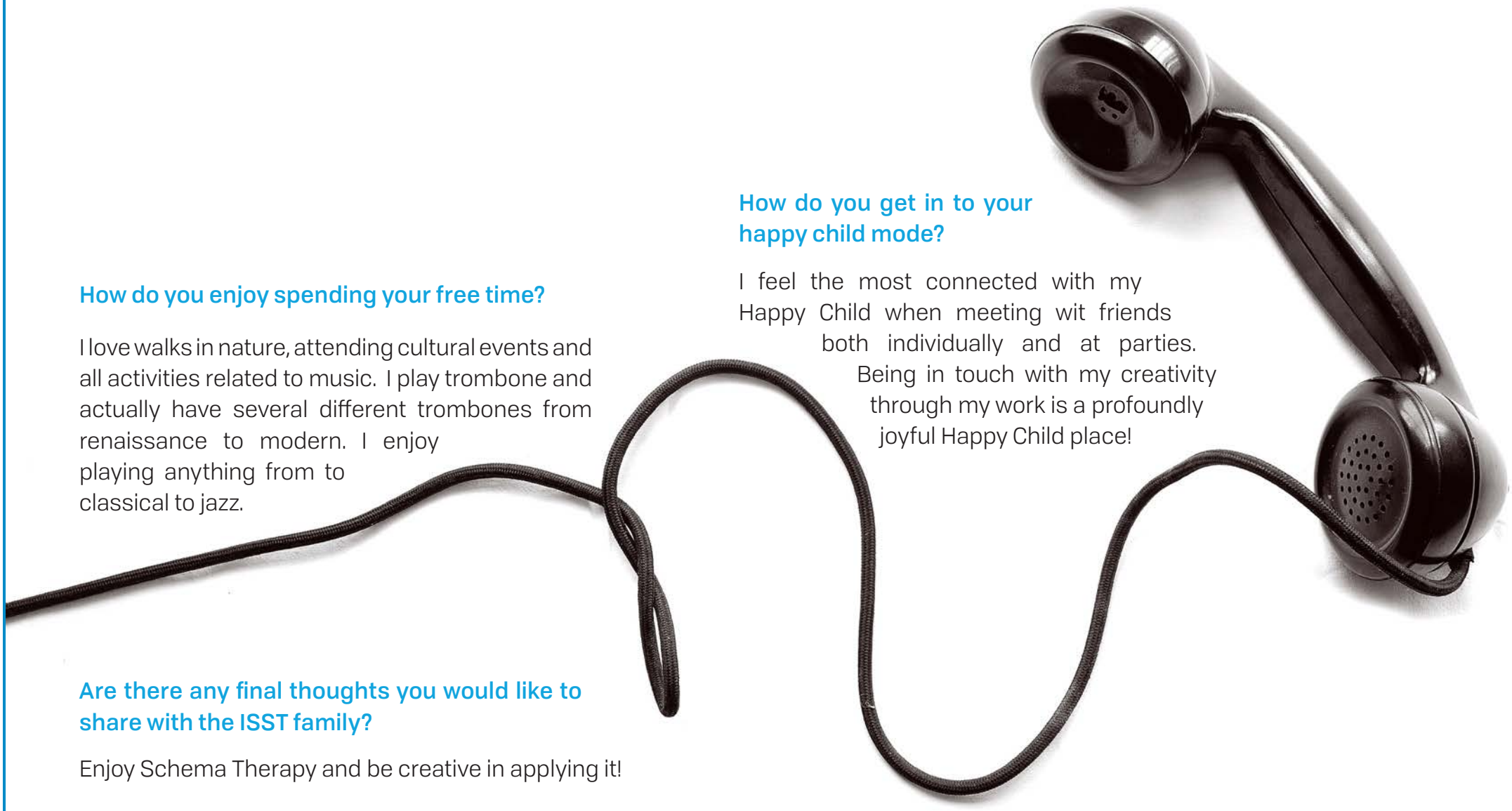
How did you first learn about Schema Therapy and how did you get your training?

I learned about ST through Dr. Tim Beck who immediately directed me to Jeff Young as his personal suggestion for a trainer for Cognitive Therapy treatment for Borderline Personality Disorders. I asked Dr Beck for direction as I was planning a Randomized Clinical Trial at that time. As it turned out that RCT marked the fortunate beginning of my training in Schema Therapy as Jeff began to train all of us therapists at that time!



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

I can see a better understanding of the most effective aspects of Schema Therapy hopefully bringing about effective changes in application. This is already happening to a great extent with shorter, time-limited treatments, limited reparenting becoming more limited than it had been initially and further group applications.
I am excited about refining & improving the theoretical model including needs, schemas and expansion of the understanding of coping through schemas and modes so that it covers more personality pathology than the current model.
I am hoping for more replication studies so that Schema Therapy is better recognized as evidence-based treatment in the future.



How do you enjoy spending your free time?

I love walks in nature, attending cultural events and all activities related to music. I play trombone and actually have several different trombones from renaissance to modern. I enjoy playing anything from to classical to jazz.

How do you get in to your happy child mode?

I feel the most connected with my Happy Child when meeting wit friends both individually and at parties. Being in touch with my creativity through my work is a profoundly joyful Happy Child place!

Are there any final thoughts you would like to share with the ISST family?

Enjoy Schema Therapy and be creative in applying it!

IMPORTANT DATES FOR YOUR DIARY

FORTHCOMING ISST CONFERENCES

Virtual Summit 2020 – tickets still available for purchase! (recordings will be available through at least the end of May, 2021!)

Virtual Summit 2021 – June 24th-26th, 2021

INSPIRE 2022 Copenhagen conference: postponed to 16-18th June, 2022 (with pre-conference welcome/social event and early check-ins on evening of 15th June)

ENLIGHT 2023, Melbourne conference: postponed (Dates to be announced)

INSPIRE 2024 Washington DC (Dates to be announced)

FORTHCOMING ISST WEBINARS IN 2021

Hosted by Richard Brouilette, Susan Simpson, Chris Hayes, Andrew Phipps

Topic: 'Practical process-based work on the Couples therapy module System'
Presenter: Eckhard Roediger
Host: Susan Simpson
Date: 10th Feb, 2021, 11:00 UTC, (12 noon CET)

Topic: 'Dealing with Addictions
Presenter: Liz Lacey
Date: May 2021 (Date TBC)

Topic: 'Dealing with Procrastination linked to EMS in Schema Therapy'
Presenter: Bahar Partou
Date: August 2021

Topic: 'Exploring Intergenerational family history, attachment and trauma issues underlying alcoholism'
Presenter: Mary Giuffra
Date: October 2021

Topic: 'Tailor-made introduction for Schema therapists into Relational Frame Theory (RFT), the functional processes and the three styles from ACT'
Presenter: Eckhard Roediger
Date: December, 2021

RECENTLY RECORDED WEBINARS, NOW AVAILABLE ON THE ISST WEBSITE:

Topic: 'Interweaving EMDR with Schema Therapy for Trauma Processing'
Presenter: Graham Taylor

Topic: 'Pushing for Anger in Cluster C Personality Disorders'
Presenter: Ruth McCutcheon & Saskia Ohlin

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

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

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

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

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