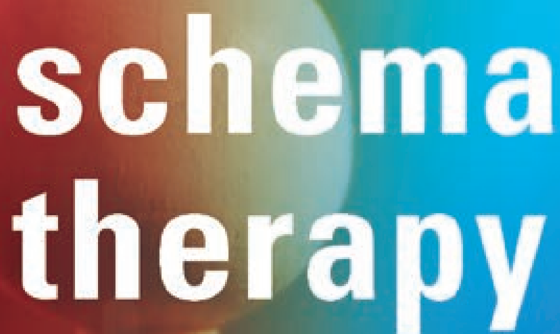

schema therapy

step by step

with children and adolescents

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Schema therapy with children and adolescents

Schema therapy is an integrative form of psychotherapy developed by Jeffrey Young. Various treatment studies have shown that schema therapy is effective in the treatment of personality disorders, persistent anxiety, and mood disorders in adults. There are indications that schema therapy is also effective for young people with personality problems.

Schema therapy assumes that every person develops schemas in their youth through an interaction of biological, psychological and social factors. When there are chronic deficits in validating a child's core emotional needs, these schemas are colored by feelings of fear, insecurity, mistrust, etc. Young describes 18 dysfunctional schemas and three types of survival strategies, the coping styles. Recently, a group of researchers proposed 3 extra schemas (Arntz et al., 2021). Patients also exhibit widely varying states of mind, which are called schema modes, modes or 'sides' of the patient. One moment certain activated schemas in combination with a coping style results in one state of mind (mode), while at the next moment the specific combination of schemas and a coping style results in another mode. Schema therapy aims to build or strengthen more healthy schemas and modes. To this end, a therapeutic stance of Limited Reparenting within the therapy relationship is used in combination with a wide range of cognitive, experiential, and behavioral methods and techniques.

We can distinguish the same schemas, coping styles and modes in young people as in adults. However, these may sometimes look different, depending on the age and developmental stage of the patient. The emphasis is generally on working with modes, because these are immediately recognizable for young people and are less abstract than schemas and coping styles. Another characteristic of working with youth is that the patient's parents/guardians are involved in the treatment, so that they learn to meet their child's core emotional needs as much as possible. In general, more materials are used when working with young people to support the therapeutic processes and make them more playful where necessary.

Introduction

This audiovisual production provides an overview of the various interventions that can be used during the schema therapy treatment of a child or adolescent. The treatment interventions are organized by mode category. Attention is also paid to the different phases within the therapy, and the differences in working with young people with mainly internalizing problems versus mainly externalizing problems.
In the scenes with parents, you can see how they can be actively involved in the treatment, and how to work with the schemas and modes of these parents. Finally, there are scenes demonstrating how to adapt schema therapy techniques to work with children of primary school age.

The aim of this production is to familiarize you with schema therapy with adolescents or children and their parents. In 86 scenes, interventions are demonstrated with two adolescent patients, one primary school aged child, and parents. For the adolescents, the interventions are tailored to internalizing problems of an adolescent girl (with development towards Cluster C personality problems) and to externalizing behavioral problems of an adolescent boy (with development towards Cluster B personality problems). All steps of the schema therapy process are shown. We start with creating a case conceptualization, introducing schemas and modes, and using experiential techniques in this diagnostic phase. To teach therapists how to recognize schemas and modes, they are demonstrated in short fragments. In addition, methods and techniques are shown to work with all mode categories. Some techniques are broken down into the different phases of the treatment; initial, middle, and final phase of therapy. Strengthening the Healthy Adolescent mode in the final phase of therapy is also demonstrated. The scenes with parents show techniques that may be applied with parents separately, or in a joint session with the patient. Finally, scenes with a younger child of primary school age are included to demonstrate how the important techniques can be adapted to treat a younger age group. For pragmatic reasons, all scenes have been kept short, but in clinical reality you can of course spend more time developing and expanding the interventions and discussing them with your patient.

In this booklet you will find an explanation with useful additional information for each scene shown. This production can be used as an integral part of a course on schema therapy or as a supplement to supervision or peer supervision. Various materials have been used in this production, including mode cards and mode figures from the 'Modi in Zicht' (Modes in Sight) series (**www.psykey.nl/producten**).

In the scenes with the primary school aged child, a living puppet is used (**www.living-puppets.de/en**) as well as smaller (finger)puppets (**www.folkmanis.com**) and basic need cards (**www.beltz.de**).

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Here you'll find the schemas of the adolescent patients in this production

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Here you'll find the modes of the adolescent patients in this production

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Explanation of the scenes

Assessment of schemas and modes

1 Rationale of schema therapy for a patient with internalizing problems

There are several ways to introduce the rationale for therapy. You can first explain a schema therapy concept and link that concept to the problems of your patient (see 'Explanation of rationale for a young person with externalizing problems').
Or you can explore the problems of your patient and 'wave in' the concepts of schema therapy. The latter option is shown in this scene. There are also variations in the tools you can use. The advantage of using figures is that the dynamics of the different modes can be made more visible by the position of those figures.

2 Rationale of schema therapy for a patient with externalizing problems

Your goal in the first sessions is to explain the concepts in schema therapy; core emotional needs, schemas, and modes.
An adolescent with externalizing problems may be inclined to react with indifference or irritation as a response to the unfamiliarity and discomfort with starting therapy. Mode cards can be a useful tool to make modes more visible. You can see the introduction of the treatment rationale as a negotiation with the patient's coping modes that may often be angry and irritated. Therefore, it's important to offer room for autonomy by allowing your patient to choose those cards that your patient feels to be the best representatives of the various modes. It is likely that your externalizing patient may not choose the card of the Vulnerable child, so make sure that it is included both in the rationale and in the final mode map of the patient.

3 Lifeline with unmet core emotional needs and development of schemas and modes

In the case conceptualization, you try to gain more insight into how, and why schemas and modes emerged. A timeline, in which meaningful events are symbolized using stones or other objects, can help to better understand the function of a coping mode. As with all interventions used in the assessment or case conceptualization phase of the therapy, the aim is to gain insight in these patterns, not yet about changing them.

4 Downward arrow technique followed by diagnostic imagery

The downward arrow technique is a cognitive way to identify schemas in which you continue to ask questions about the underlying meaning of concrete experiences. In the scene you see an example of how you can link that cognitive technique to a more experiential technique of imagery. In the case conceptualization phase, the technique is intended to gain more insight, not yet to change anything. Therefore, there is no rescripting in a diagnostic imagination, even though you sometimes feel the urge to do so. By visualizing a nice place at the end of the exercise, you can finish the exercise pleasantly. In the debriefing, meaning is given, and that reflection afterwards is just as important as the exercise itself.

5 Creating a mode sequence of activated schemas in the parent-child interaction

At the start of therapy, the patient may feel confused and overwhelmed by schema activating situations in their daily life.
In the assessment phase, this tangle of emotional, cognitive and behavioral responses is unraveled using the language of modes. Once there is more insight into your patient's different modes, interactions with important others can be unraveled in the same manner. The mode sequence offers the opportunity to reflect upon difficult interaction patterns, and how to break free from them.

6 Mode model and therapy goals

For children and adolescents, you try to make the mode model as visual and insightful as possible, appropriate to their emotional age. No matter how colorful and visual it is drawn, a two-dimensional drawing remains somewhat abstract. Using figures to represent the modes can help bring the different sides of your patient to life. The case conceptualization, including the mode model, is the cornerstone of the therapy. It is the basis from which concrete therapy goals are formulated to improve the patient's symptoms and dysfunctional patterns, taking into account all modes that contribute to these symptoms and patterns.

Working with child modes

1 Providing care to an adolescent with internalizing problems

Providing care takes different forms, depending on the relevant core emotional needs of the patient at that moment. Internalizing problems naturally require secure connection, but you also encourage self-expression. By giving space to express emotions and explicitly validating those feelings, your patient learns that expressing feelings is good.

2 Providing care to an adolescent with externalizing problems

The need for boundaries is often noticed first in contact with an adolescent with externalizing problems. However, safety and connection are also relevant needs for this adolescent, even if the patient seems to repel you during the session. Providing care for this adolescent is therefore aimed at maintaining and validating connectedness. However, the adolescent's Window of Tolerance may be small and therefore, creating connection by keeping the patient in the session may already be an achievement. A way to keep your patient within this Window of Tolerance is to talk to an empty chair, representing the Vulnerable side. While staying in an observers' position your patient listens to your involvement and compassion. By providing care 'under the radar', the patient may be able to tolerate that compassion and involvement better than if it were expressed directly to him/her. Make your patient aware of those (primary, albeit minimal) pleasant responses when hearing compassion so that this can be framed as a positive experience.

3 Imagery rescripting for the Vulnerable child mode

Imagery rescripting is an evidence-based technique that helps to generate corrective emotional experiences. You provide a brief rationale about the intervention and the usefulness of the exercise. Patients have indicated that they find it important to know approximately how long the exercise will take, so that there is predictability, and therefore safety, in their effort to comply with the exercise. The exercise often starts with visualizing an unpleasant recent situation and the emotions it evoked. These evoked emotions function as an affect bridge to the past and meaningful experiences that have formed the schemas that are the roots of the patterns in the patient's life.
In the initial phase, as a therapist you step into the image to rescript the course of the visualized events. When working with adolescents, you address the adolescent's caregivers, but in a way that suits the current situation in which the patient is often still dependent on the parents. In addition to correcting the unpleasant events, you also try to stimulate the needs for play and spontaneity, so that the patient gains experience with healthy emotion regulation. The debriefing afterwards is as important as the exercise itself; in this debriefing, conclusions are drawn and meaning is given to the experiences the patient has had in the exercise.

4 Venting anger for the Angry child mode

The adolescent with externalizing problems can sometimes become too

angry, i.e. not in proportion to the specific reason for that anger. The therapist's natural reaction might be to limit that intensity, and focus primarily on the content of the anger at that moment. However, the intensity of the anger stems from injustice experienced in the past. So, the current anger is an expression of this old perceived injustice. Therefore, it is important to try and provide space for ventilating that anger. Once the anger has been expressed, and the underlying pain of unmet emotional needs is more palpable and visible, you can first offer compassion before discussing with the patient how he could learn to deal with that anger in a more functional way in the future.

5 Chair technique stimulating the Angry child mode

An adolescent with internalizing problems often has too little anger. That can be problematic, as anger is a source of strength that is needed to break persistent patterns. Moreover, anger is a healthy way of emotion regulation, helping to express tension and stress in a healthy way. However, for adolescents with internalizing problems anger is also a schema-triggering emotion. That is why it is better to opt for a playful way to stimulate anger. Another way to help your patient is to actively participate yourself, to model what you may be angry, irritated or frustrated about.

6 Chair technique with the Undisciplined child mode

After you have identified the Undisciplined child mode, you make the patient more aware of this side of the patient. A role reversal can help to not only recognize that side but also its effect on the other person. In the initial phase of the treatment, in which you still provide a lot of direction, you help your patient to see what the disadvantages of the Undisciplined side are and what the goal of therapy will be. In the middle phase of therapy, you coach the patient to actually correct that Undisciplined side him/herself. Coaching sometimes simply means having your patient repeat healthy messages, with more volume. Such corrective experiences must be consolidated and remembered. A transitional object, now in the form of a small wooden figure, may help with this.

7 Happy child exercise

There is a huge variety of exercises that can help to stimulate and validate the Happy child mode of children and adolescents. This scene demonstrates one of those playful exercises. It's important to do these exercises in the session, even if your patient does not ask for it or initially finds it strange or even ridiculous. It may feel awkward or strange to your patient at first, but with these exercises you teach an essential lesson, i.e., that you can channel tensions in a healthy way.

Working with 'parent' modes

The word 'parent' is in quotation marks here, because this term suggests that the critical messages, which are characteristic of the modes within this mode category, have been fed only and always by the parents. This is incorrect; the messages can also come from other attachment figures, either adults who have been influential (for example a teacher or sports coach) or peers (for example in bullying behaviors). We chose to stick with the term to define the mode category in line with existent literature on schema therapy. However, below we'll speak of the 'Demanding critic' instead of the 'Demanding parent mode'.
Imagery rescripting is a helpful technique when addressing 'parent' modes. Apart from the scene demonstrating Imagery rescripting with the Guilt-inducing critic, you'll find other examples of this technique in the scenes 'Imagery rescripting for the Vulnerable child' and ' Imagery rescripting (starting from a situation triggering the Angry protector).

1 Chair technique with the Demanding critic

The chair technique can be a powerful tool that helps the patient to distance themselves from a 'parent' mode, such as the Demanding critic in this scene. First, have your patient voice out the messages from the Demanding critic in a separate chair, as if she were that Demanding side. On the chair of the Vulnerable side, the patient can then reflect on the stress and tension evoked by the demanding messages. By standing up, having an overview like a Healthy adolescent, your patient can gain more insight into what is happening inside her. In the initial phase of therapy, you will have the lead in contradicting the Demanding critic. In the middle phase you will start to ask the patient more and more to take part in addressing the Demanding critic.

2 Chair technique with the Punitive critic

In the initial phase of therapy, your patient will still believe the punitive messages to be true. The first goal in this phase of therapy will be to teach the patient to recognize the Punitive critic as internalized beliefs. One way of creating this awareness is to first redefine the punitive statements about oneself as the Punitive side. Secondly, you can start fighting this side of the patient. Your patient may respond to you opposing the Punitive side by becoming critical at you, or starting to giggle. This might cause you to feel inhibited to fight the Punitive critic with the use of a chair technique. Don't be deterred and keep fighting the Punisher's empty chair. The patient's comments about the technique on the one hand arise from discomfort to the healthy messages they hear from you, which feel so unfamiliar to them. On the other hand, an awkward feeling might have been triggered when you start to address an empty chair as a representation of their Punitive side, causing them to react with criticism or laughter.

3 Imagery rescripting fighting the Guilt-inducing critic

Dealing with the guilt-inducing critics in imagery rescripting prove to be challenging. For example, the patient does not allow you to come into the image to support the child in the image, or is unable to divert her attention from what her parent needs in the image. In this scene, some suggestions are provided to cope with these challenges. For example, you can bring a colleague into the image who will support the mother, thereby allowing you to fully focus on the core emotional needs of the younger patient in the image. You can also use the mode language as a way to differentiate between the dysfunctional side of the mother who is not able to respond to the patient's needs, and a healthier or happier side of the mother who is able to meet some of the needs of the patient. This differentiation makes it more bearable for the patient that you address the dysfunctional behavior of her mother.

4 Challenging the Punitive critic in a playful way - compilation

Another way to fight the Inner critic and to internalize healthy conclusions from therapy is to use playful exercises, such as shooting with nerf guns at the Demanding side, or tearing up or burning a drawing of the Demanding critic. A powerful variant of this is to smash a plate including the written critical message that has caused suffering for your patient. The force of smashing can be a physical release of tension but also of anger at the (origin of the) Demanding critic.

5 Cognitive technique fighting the Demanding critic

This scene shows a more cognitive approach in addressing an inner critic. The first step is to become aware of the Demanding critic and its messages, for example by writing those demanding beliefs down on a piece of paper. In the

middle phase of the treatment, you invite the patient to think more about alternative, healthier beliefs. The drawing of the Demanding critic and the use of post-its to cover it with healthy messages, whilst freeing the Vulnerable side from the demanding messages, makes this cognitive technique more visual and therefore more emotional. It gives the opportunity to use more modalities than just thinking and writing.

Working with coping modes

1 Empathic confrontation of the Detached protector in the different phases of therapy

The empathic confrontation is aimed at helping the patient to gain insight in her different sides. This insight might then serve as a stepping stone towards behavioral change. On one hand, you confront your patient in a personal way with the effect of the Detached protector on you. On the other hand, you also provide understanding about the background of that protector and what function it has for your patient. Empathy and confrontation may be seen as two knobs on a tap, where you look for the right 'temperature' at which your patient is confronted in a way that it is still tolerable. In the initial phase of therapy, the emphasis will have to be on empathy. In the middle phase, the emphasis gradually shifts towards confrontation; your patient must come to see and understand that the protector must become less strong. In the final phase, the emphasis is even more on confrontation. You can be confident that at the end of the therapy the therapeutic relationship will have become so strong that it can withstand the increased pressure of a clearer confrontation.
The aim in this final phase of therapy is to actually achieve a behavioral change.

2 Empathic confrontation of the Self-aggrandizer in the different phases of therapy

The empathic confrontation takes a different form in the initial phase of therapy as compared to the middle and final phases. In the initial phase, the emphasis is on empathically explaining the origin and maintenance of behavior, making it easier for the young person to recognize this behavior. In the middle phase, you gradually confront the patient more with the adverse aspects and consequences of the dysfunctional behavior.
In the final phase, you can confront the patient even more directly with the dysfunctional coping mode. You also focus on the patient's responsibility to actually change the coping behavior.

3 Providing direction as part of limited reparenting

As a role model for the Healthy side, you will have an opinion on relevant topics in the life of your patient, e.g., family, school, friendships and relationships. You will certainly express that opinion and thereby act as a healthy compass for your patient in these sometimes complicated matters. You will not only indicate what you want your patient to do or not to do, but you also explain why you find this so important. You use core emotional needs as the most important reasons to actively provide direction to your patient.

4 Visualizing the Angry protector to connect with the Vulnerable child

The aim of an imagery exercise is ultimately to connect with the Vulnerable side of the patient. However, the protector can be so strong that it might be impossible to make contact with the feelings. A first attempt to bypass this protective side of the patient may be to ask the patient to visualize a photo from childhood, focusing on sensory information. If that doesn't work, another option might be to ask your patient to open their eyes and work on the protector in a different way, for example using a

chair technique. However, you can also ask your patient to visualize the resistance felt within the imagery exercise or in the session. This gives you the opportunity to negotiate with the protector within the visualisation. As an observer, your patient watches you negotiate with the visualized protector and describes how the protector reacts. This observer perspective creates more distance from that protector and allows for more contact with the Vulnerable side.

5 Imagery rescripting (starting from a situation triggering a coping mode)

There are all kinds of starting points for an imagery rescripting exercise. In this scene, the starting point is a recent situation with the Angry protector. The imagery exercise is used to clarify the origins of this protector and to provide a corrective emotional experience. It's important to take your time when visualizing the situation: by making the situation as vivid as possible, paying attention to visual details, the exercise will become more emotional. Ask your patient to imagine it as if it were happening right now. The right time to step into the image in order to rescript the visualized events is mainly determined by the level of emotional arousal of your patient: The exercise must be emotional to be meaningful, but those emotions must still be tolerated by your patient. In the initial phase, you will enter the image to do the rescripting.
Rescripting the image allows you to be a role model for the Healthy side, providing care and meeting the core emotional needs of the child in the image. Talking in a different direction when addressing the antagonist may add to the liveliness of the exercise.
The corrective experience you provide has two elements: on the one hand you address the punitive or demanding antagonist, and on the other hand, you will validate the needs of the Vulnerable child. In this way, meaningful experiences are generated in the imagination. The meaning given to those experiences is being discussed in the debriefing. This debriefing is therefore an equally important part of the exercise as the visualization itself. The experience may be further consolidated with the use of a transitional object or homework assignments.

6 Step by step limit setting

Immediate boundaries might be necessary when your patient exhibits unsafe behavior. For other dysfunctional behavior that might not be creating unsafety, limits are set step by step. First, you identify the behavioral pattern and list the actions you took so far to change it. Then, you explain in a personal way to the patient what makes this behavior problematic, and why it needs to stop. You also explicitly state what the desired behavior is. You can agree on a consequence if the patient does not adhere to the limit setting. This consequence must make it tangible to the patient that the limit is something to take into account. The sort of consequence you decide on may vary per patient; for one patient an appropriate consequence is that the patient has to apologize for his behavior, for another patient to do an extra homework exercise, or to arrange a meeting with patient and parents to talk about the problematic behavior, et cetera.
Given the need for autonomy of adolescents, it can be useful to let the patient think along about an appropriate consequence.
The next time the patient does not adhere to the agreements made, first repeat the boundary and explain again the consequences. You may want to discuss a next consequence if the patient is again unable to keep to the agreements.

7 Limit setting of the Bully and attack mode

When safety is at risk, boundaries must be set immediately. In this scene the patient is very angry, standing close to the

therapist and making threatening gestures. At this point it helps to repeat your patient's name, possibly holding up your hands in a 'Stop gesture'. First provide a safe space to talk before you address the content of the anger.

8 Chair technique with the Compliant surrenderer in the different phases of therapy

a Initial phase of therapy

You start by identifying the Compliant surrenderer mode, pointing this mode out to the patient. Then you ask the patient to sit on another chair and 'be' that mode, thereby having this chair represent the Compliant surrenderer mode. With your patient playing the role of the Compliant surrenderer, you then interview this mode. This scene starts right after this interview. The goal of this technique is to get past the Compliant surrenderer mode, and therefore you negotiate with this mode. Negotiating includes expressing understanding for the helping function of the protector in the past, but also asking for contact with the Vulnerable side. Because the patient in this scene is not able to connect with the Vulnerable side, you help by expressing those feelings in the chair of the Vulnerable side (modelling it). By allowing the patient to express the same feelings immediately afterwards from that same chair, she can more easily make contact with her Vulnerable side. You then help to create an awareness of the disadvantages of the Compliant surrenderer mode. These insights and new experiences may be consolidated by writing them down.

b Middle phase of therapy

In the middle phase your role changes from providing guidance into coaching of the Healthy adolescent. The patient is asked to put herself in the role of that Healthy side and to use a symbol of the Vulnerable side (in this scene a pillow). That will help her to take on that role and stand up for the feelings and needs of the Vulnerable side. You actively guide the process and assist the patient where necessary. Empowering the Healthy adolescent means that the patient is encouraged to actively think about her own opinions and needs.

c Final phase of therapy

In the final phase, your role changes into becoming a more encouraging coach from the sidelines. The end of the therapy is approaching and the patient can now be expected to better and more fiercely apply what she has learned. You further challenge the Healthy side of the patient by playing the role of the Compliant surrenderer mode on its chair. The patient, from the perspective of the Healthy adolescent, must then try to convince you, in the role of the coping mode, of the healthy arguments. Stimulating the patient to express these healthy views helps her to gain more ownership over these rational considerations of the Healthy side.

9 Chair technique with substance abuse

You choose to place the substance, on which the patient has become dependent, on a chair. Folding paper into a life-size joint that can be placed in that chair makes the dialogue with this substance more personal. The distance created with the chair technique also helps to emotionally distance the patient from the substance. By addressing the drug, almost as if it's a person will help to further strengthen that distance. Take your time when considering both the pros and cons in order to get the patient to actively think about it in a realistic way. To consolidate the process of calm and realistic thinking, you may give a homework assignment which, in this scene, is to write a letter to the drug. At this stage of the therapy, it might be a letter with room for all the ambivalent feelings that the patient still experiences.

10 Flash card for coping mode in the different phases of therapy

There are several ways to consolidate the insights or experiences gained from the session so that they are better remembered. The audio flashcard has the advantage that the therapist's voice and messages are audible between sessions and therefore can be better internalized. In the middle phase of therapy, the adolescent is coached to actively look for ways to remember the messages from therapy. Writing down the messages, combined with a self-chosen object, contributes to the messages from the therapy increasingly becoming the messages of the patient himself. All insights and healthy messages of the therapy may be gathered as notes on a key ring, so that the patient has them all together as a reminder of a healthy perspective, building blocks of their own Healthy side. You can encourage the patient to read them over as a means of support in practicing new, healthy behaviors in the final phase of therapy.

Strengthening the Healthy side

1 Therapy evaluation with the Healthy adolescent: the line exercise

One way to strengthen the Healthy side is to consciously reflect on all the insights acquired and the changes that have already taken place in therapy. The line exercise previously used in the case conceptualization phase can now be used again. Now, however, symbols of the insights and experiences gained are laid down along the line that represents the therapy thus far. This exercise also offers the opportunity to look ahead; What are other goals that your patient would like to work towards? And what are concrete steps that can be taken in the coming week to work towards these goals?

2 Future imagery

The power of imagination cannot only be used to validate unmet core emotional needs in the past. The imagination can also be used to practice healthy, new behavior by visualizing this new behavior. This increases the chance that your patient can actually break old behavioral patterns in schema-triggering situations. Start the exercise by conjuring up the image of the Healthy adolescent who will have to take control later in the exercise. This is a form of priming that makes the Healthy side more accessible when schema-activating situations are visualized later in the exercise. You then ask the adolescent to visualize a schema triggering context that probably will present itself in the near future. You invite the patient to reconnect with her Healthy side, and apply the three steps of that healthy side. There is evidence that observing this healthy, new behavior, from an observers perspective ("She is now doing/saying..."), is more effective than visualizing new behavior from the first-person perspective ("I am doing/ saying now...").

3 Strengthening the Healthy adolescent with three chairs

In the middle and final phases, the therapy increasingly focuses on strengthening the Healthy adolescent. In the initial phase, you have modeled three steps of a Healthy side that the young person now needs to master more independently. These three steps are: 1. Compassion (being kind to yourself), 2. Cognitive restructuring (why are those critical sides and protectors not right in this situation?), 3. Behavioral modification (How are you going to handle this situation in a healthy way?). In a chair technique, the chairs can now symbolize these three steps instead of the modes they have often represented.

4 Behavior modification: skills training in setting boundaries

Patients with internalizing problems find it difficult to feel what they need as well as what their boundaries are. This scene

shows a visual way in which you can help the patient to recognize and monitor those needs and boundaries. The patient is invited in various ways to pay attention to her feelings and needs. Placing the line as a symbol of her boundary, your questions and approach towards the line on the floor are tools in helping the patient to become aware of her boundaries. Writing down that boundary on a piece of paper and actually saying that message out loud helps the patient to really take ownership of the insights obtained in this exercise.

5 Transitional object

The use of a transitional object as a representation of the corrective experiences in therapy changes over the different phases of therapy. In the initial phase, these are objects that symbolize the Vulnerable side and the care for that vulnerability. Examples of such transitional objects are stones, key rings, cards, figures, etc. In the middle phase, the therapy is increasingly focused on strengthening the Healthy side of the adolescent. This scene shows an example of that. You can also start using transitional objects that provide more options for the Healthy adolescent to give their own interpretation, such as a card on which the adolescent has to write a healthy message, or a symbol of the critical side that the adolescent can fight. In the final phase, the objects you provide are mainly aimed at further strengthening and generalizing the Healthy adolescent and the autonomy that becomes increasingly central in the completion of therapy. It is now up to the adolescent to continue working with everything that has been learned.

Working with parents

Working with parents is a characteristic element of schema therapy with children and adolescents. In this part, you will find some examples of working with parents in schema therapy. More techniques are shown in the scenes that concern the primary school aged child. The techniques demonstrated in those scenes may also be applied when working with adolescents and their parents.

1 Imagery rescripting with a parent to improve parenting skills

In schema therapy for children and adolescents, some treatment sessions are also planned with one or both parents alone. In these sessions, the themes or problems of the parents in relation to their child can be worked on. These sessions can be compared to schema therapy for adults (see 'Schema therapy, step by step'), with the difference that it involves a smaller number of sessions and that the interaction with the child is central. So, these sessions with the parents alone cannot be seen as a complete schema therapy. If necessary, the parent can be referred for individual treatment.
In imagery rescripting, a conflict situation between the parent and the adolescent/child is the starting point to identify old, maladaptive schemas of the parent. The origins of these schemas can be identified with the help of an affect bridge. By rescripting this meaningful situation from the childhood you can act as a role model for the Healthy side of the parent. On the one hand, the rescripting provides a corrective emotional experience that may serve as an antidote to their own schemas. At the same time, you model healthy behavior, which can be internalized by the parent, offering an example of how to act as a parent towards the patient. When the Healthy side of the parent is strong enough, you coach the parent in rescripting her own childhood images, validating the needs of the child she used to be. That's what this scene demonstrates. In the debriefing, you talk about the origins of the schemas that are activated in the here and now by their child, 'and about what the parent needs to cope with their

own inner child and at the same time respond to their real child (i.e., the patient) in a healthy way.

2 Mode clash between parent and child: chair work

Parents are actively involved in the schema therapy for children and adolescents. Their role in the case conceptualization phase can be to gain more insight into family dynamics.
They also play an important role when practicing new behaviors and new ways of interacting with each other in the middle and final phases of therapy. The role play in this scene consists of several steps. In the first step, a mode clash is replayed as it actually took place, with the family members playing themselves. In the second step, the roles are reversed to create more insight and understanding of each other's feelings and behavior. In the third step, underlying needs and feelings are expressed to each other. These experiential role plays are alternated with cognitive reflections and summaries to highlight and consolidate the insights gained.

3 Practicing healthy behaviors in imagery

In the middle and final phases of the therapy, there is more emphasis on breaking the behavioral patterns. A future-oriented imagery is a preparation for these new behavioral patterns. It helps to work in a targeted manner, i.e. to discuss which difficult situation and which new behaviors will be visualized in the exercise. By helping the patient and parent to connect with their own Healthy side before visualizing the difficult situation, it can be easier to reconnect with their Healthy mode when their maladaptive schemas are triggered in the visualisation of the difficult situation. You coach both patient and parent how to deal with this situation in the imagery in a healthy way. In this scene, the exercise has been kept short for pragmatic reasons, but in clinical reality you can spend more time building up and expanding the future situation and the new, healthy behaviors.

Working with a child of primary school age and parents

1 Introduction to the schema therapy model – core emotional needs

At the start of schema therapy, it is important to explain what schema therapy is and how it works. With a younger child, you want to make sure to explain this in a comprehensible way. The core emotional needs can be a good starting point to explain the rationale of schema therapy. You can talk about the needs in general (what core emotional needs do children have?), about the needs of both patient and parent in the here and now, and about their needs when they are in conflict with each other or confronted with another difficult situation in daily life. Need cards or drawings may be used to visually support the explanation.

2 Introduction to the schema therapy model – schemas

After discussing the core emotional needs, you explain that maladaptive schemas can develop when those needs are frustrated. You may use metaphors when talking about schemas, e.g., schemas as 'emotional wounds' that can still hurt in the here and now. Another practical, and also somewhat playful way to explain the influence of schemas on the way you look at yourself, others and the world, or the way you interpret information, is the use of glasses. This exercise demonstrates how the patient and parent may look at the same situation from their own perspective, i.e., through the 'glasses ' of their own schemas.

3 Mode sketch with a child

In line with the perception of a younger child, you can use creative tools to make

a mode model. Various adjustments are conceivable when working with young children, such as choosing large or small dolls or cuddly toys, making even more use of drawing facial expressions, coloring or pasting those dolls and finding language and names that suit the child.

4 Mode work with finger puppets

Although the chair techniques can be used with a child of primary school age, the use of puppets or other things that represent the modes may be a good alternative. By letting the child verbalize the thoughts, feelings and actions of the puppet representing the mode, you can create a mode dialogue. The mode model of the child thereby comes to live, and all modes can get a chance to be heard. You can build on this further to create more distance between the child and dysfunctional modes.

5 Mode sketch with a parent

After explaining the child's mode model to the parent, you can also make a mode model for the parent. It is important to focus on the schemas and modes that are activated in the interaction with her child. The mode model of the parent can serve as a basis on which interventions are applied to improve parent-child interactions.

6 House of generations (1) – explaining the link between parental difficulties and the parent's childhood.

Imagery exercises using an affect bridge may be used to examine the link between difficulties in the parent-child relationship and own childhood experiences of the parent from their past. Another way of examining these links, or the origin of schemas that are triggered in the current interactions with their child, is to use family constellations. You start with various family constellations of the current family of the parent, and then with family constellations of the family of origin of the parent. By placing the current family constellation in a difficult situation on top of the constellation of the family of origin, you can demonstrate how a maladaptive schema and co-occurring thoughts and feelings may travel from the past to the here and now.

7 House of generations (2) – reparenting own inner child and using positive schemas

Building on previous work with the house of generations (see scene 1 of this topic), you can let the parent choose symbols to represent positive schemas or strengths. These positive schemas or strengths can help the parent to be compassionate about 'old' feelings that are activated in the current family situation. You can bring the child from the bottom level to the upper level, inviting the parent to talk to her own inner child in a compassionate, warm way. You want to learn the parent to first pay attention to their inner child, before dealing with their real child in the current difficult family situation.

8 Strengthening the Healthy modes of parent and child

In the middle and final phases of therapy, you want to focus more on training the Healthy sides of both patient and parent. You can do that simultaneously with both patient and parent, so that they can experience how that feels in the interaction with each other. You can use representatives of the Healthy sides of the patient and parent (in this scene owl puppets). You encourage both the patient and parent to get in touch with their own Healthy mode, and to practice in engaging with each other in a healthy way. Taking a photo of them with the owls can help as a reminder to use their Healthy sides in between sessions.

9 Skills training for a parent using a live puppet

Skills training for the parent is an important part of schema therapy for children and adolescents. In order to make it more realistic and experiential, a live puppet may be put on an extra chair representing the child. There are two scenes: one of a skills training in the initial phase of therapy, and one in the middle/final phase of therapy.

a. Initial phase of therapy

In the initial phase, you can create a script that the parent may use in a schema triggering situation with her child. In the first scene, it is demonstrated how you may coach the parent to practice this script with the live puppet on the extra chair. By learning the parent to stay in touch with her own inner child, she can better connect with her Healthy adult and deal with the oppositional behavior of her daughter.

b. Middle/final phases of therapy

In the middle and final phases of therapy (or whenever you feel the parent is ready), you can make the exercise more challenging by playing the difficult behavior of the child with the live puppet. This is shown in the second scene. Your counterplay makes the exercise more realistic, and gives the parent a chance to stay tuned with her Healthy adult mode, even if the child may initially not respond well to the prepared script.

10 BONUS: Session of skills training for a parent using a live puppet

This scene shows the unedited version of the session with a parent in which skills training is applied using a live puppet (see scenes 9a and 9b above).

Schemas - examples

1. Emotional deprivation
2. Abandonment
3. Mistrust/abuse
4. Defectiveness/shame (patient with internalizing problems)
5. Defectiveness/shame (patient with externalizing problems)
6. Social isolation
7. Failure
8. Insufficient self-control
9. Subjugation
10. High standards

Modes - examples

1. Vulnerable child (patient with internalizing problems)
2. Vulnerable child (patient with externalizing problems)
3. Angry child (patient with internalizing problems)
4. Enraged child
5. Undisciplined child
6. Happy child (patient with internalizing problems)
7. Happy child (patient with externalizing problems)
8. Demanding critic
9. Punitive critic
10. Compliant surrenderer
11. Avoidant protector
12. Detached self-soother
13. Self-aggrandizer
14. Bully & attack
15. Healthy adolescent (patient with internalizing problems)
16. Healthy adolescent (patient with externalizing problems)

Exercises

1. Identifying schemas (patient with internalizing problems)
2. Identifying schemas (patient with externalizing problems)
3. Identifying modes (patient with internalizing problems)
4. Identifying modes (patient with externalizing problems)

Therapists

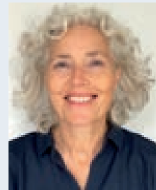
Marjolein van Wijk-Herbrink

Marjolein van Wijk-Herbrink, PhD, is a psychologist and schema therapy supervisor/trainer registered by the Dutch and international societies of schema therapy. She has extensive experience with schema therapy, CBT and EMDR for adolescents and adults and works in her own practice for training, supervision and implementation of schema therapy. In 2018, she obtained her PhD on schema therapy with adolescents from Maastricht University. She implements schema therapy in various settings, for example by training and coaching treatment teams in creating a schema therapeutic treatment climate.
She edited a Dutch book on applied schema therapy in children and adolescents (Roelofs, van Wijk-Herbrink, & Boots (2020). Toegepaste schematherapie voor kinderen en adolescenten. Houten: Bohn Stafleu van Loghum). She also wrote several articles and book chapters, for an overview see: www.psykey.nl/literatuur.

Christof Loose

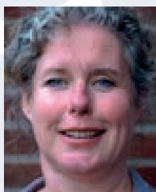
Christof Loose, PhD, is a clinical psychologist and psychotherapist for children and adolescents (CBT). He is a certified trainer and supervisor in Schema Therapy for Children and Adolescents (ISST e.V.). He works in his own Private Practice in Dusseldorf, and is Coordinator of the ST-CA Curriculum in the Institute of Schema Therapy Cologne (IST-K).
He was Chair of ISST Committee for Children and Adolescents from 2013-2017, and again since 2023. He is known as editor and author of ST-CA books and Video-Learning (DVD), and conducts worldwide workshops and seminars in schema therapy for children, adolescents and parents.
More info about ST-CA is on the website www.schematherapy-for-children.de or in the book 'Schema Therapy with Children and Adolescents: A Practitioner's Guide" (Loose, C. Graaf, P. Zarbock, G., & Holt, R.A., 2020).

Hélène Bögels



Hélène Bögels is a clinical psychologist/ psychotherapist and works at the Reinier van Arkel Center for Adolescent Psychiatry in the Netherlands and in her own practice.
Since 2014 she has been teaching schema therapy courses for adults and adolescents. She is a schema therapy supervisor certified by the Dutch and international societies for schema therapy, as well as a certified CBT supervisor. She is chair of the International Connections Committee of the Dutch society for schema therapy and a member of the Training and Certification Advisory Board of the ISST.
She co-edited a Dutch book full of case descriptions of schema therapy (Hornsveld, H., Bögels, H., & Grandia, H., (ed.) (2021). Casusboek schematherapie. Houten: Bohn Stafleu van Loghum).

Natalie van Oort



Natalie van Oort is a psychotherapist, registered psychodrama therapist and schema therapy supervisor certified by the Dutch and international societies for schema therapy. She is also a certified CBT supervisor. She works at Altrecht at the young adult department. She has extensive experience in providing individual and group schema therapy to young adults and adults with personality problems and provides training in schema therapy and cognitive behavioral therapy.

Jeffrey Roelofs

Jeffrey Roelofs, PhD, is a clinical psychologist and psychotherapist. Over the past 15 years he has specialized in CBT, schema therapy and EMDR. He is a schema therapy supervisor certified by the Dutch society for schema therapy. He works with children, adolescents and adults with internalizing disorders, including anxiety, depression, trauma and personality disorders. In addition to his clinical work at Youz Maastricht and in his own practice, he is an assistant professor at Maastricht University. His research focuses on the schema therapy model and the effects of (group) schema therapy in young people, people with eating disorders and on the integration of Infant Mental Health (IMH) with schema therapy. He co-edited a Dutch book on applied schema therapy in children and adolescents (Roelofs, van Wijk-Herbrink, & Boots (2020). Toegepaste schematherapie voor kinderen en adolescenten. Houten: Bohn Stafleu van Loghum). An overview of his other publications can be found at: https://www.researchgate.net/profile/Jeffrey-Roelofs/contributions.

Patients

Role of patient: Amy

Actress: **Kiara Frandonk (International Native Casting, Amsterdam)**

Amy is a 15-year-old girl. She lives with her parents and has a sister (+2 years old) with whom she has little in common. Her sister rebels against their parents and shows behavioral problems.
Amy is shy, generally quiet and withdrawn. She can experience strong emotions of fear/panic and sadness. She lacks energy and thinks she is worthless. Sometimes she has suicidal thoughts. Her DSM-5 diagnosis includes persistent depressive disorder and traits of Cluster C personality pathology.
Amy has a few friends but doesn't quite feel like she belongs. She fears that her friends will prefer other girls over her. At primary school, she already felt that she didn't fit in with the other children. She is in pre-university education and works very hard at school, often at the expense of free time.
Amy's father is a hardworking man who spends a lot of time away from home, travelling for work. He does not interfere much with her upbringing, but when he's around he emphasizes the importance of homework and good grades at school. He feels a little uncomfortable when Amy expresses feelings, so he tries to joke about it or divert her attention away from it. There are relationship problems between Amy's parents, but within the family they do not talk about the problems, and they do not want other people to know about it either.
Amy's mother tries to connect with Amy, but has many concerns about Amy's older sister and also struggles with depressive feelings herself. She encourages Amy to talk to her about anything that's on her

mind, but she is overloaded and finds it difficult to deal with Amy's feelings. She emphasizes the importance of making responsible choices. Amy's mother is quite perfectionistic, and wants others to do things her way.
Amy is motivated for therapy. She wants to experience more energy, feel happier and have more self-confidence.

Role of patient: Tim

Actor: **Fionn Lacken (International Native Casting, Amsterdam)**
Tim is a 17-year-old boy who lives with his mother and his half-sister (10 years old). His father has been out of his life since he was six, although there is occasional contact. Tim has a group of friends, mainly older boys, with whom he spends a lot of time on the street. He regularly skips school. Lately, he comes into contact with the police on a regular basis (stealing, fights) and smokes cannabis every day. His DSM-5 diagnosis includes a conduct disorder, parent-child relational problems and traits of cluster B personality pathology.
Tim's father used to be violent towards his mother and Tim. When Tim was six years old, his parents got divorced. His father stalked the family for a while, frightening them by posting on their doorstep or smearing mud on the windows. Tim's mother describes his father as an impatient, explosive man who frequently lost his temper. Afterwards he always expressed regret and made an extra effort to be kind to them, which made it difficult for his mother to leave him. Tim's father has been convicted of several violent crimes and is currently serving a prison sentence.
For a description of Tim's mother, see the role of Tanya.
Tim starts therapy because his mother and juvenile probation officer want him to. He has little confidence that therapy will help him and he thinks it is all 'nonsense". However, he does suffer from the difficult relationship he has with his mother, and sometimes he expresses that he would like to see this improved.

Role of patient: Ivy

Actress: **Selma Chadid (International Native Casting, Amsterdam)**
Ivy is a 10-year-old girl who regularly has tantrums at home. She screams, swears, cries, and breaks things. She regrets this later, but at the moment she is unable to manage her anger. At school she is a shy, withdrawn girl who finds it difficult to make friends and express herself. She loves animals and likes to cuddle the neighbor's dog. Her neighbor is an older lady who regularly takes care of her when her mother has to work. Ivy looks up to her older half-brother Tim. She loves him, but is sometimes a little afraid of him because

Tim and their mother can have serious arguments.

Ivy's parents separated before Ivy was born. In the first years there was regular contact and Ivy also spent weekends with him at his house. There were many (verbal, and sometimes physical) arguments between her parents. Ivy's father moved to America three years ago. Since then, he occasionally contacts Ivy through video calling and visits her once a year, when he is in the Netherlands.
Ivy would like to learn to deal with her anger.

Role of patient: Tanya, mother of Tim and Ivy

Actress: **Roosje Nieman (Moeder Anne Casting, Amsterdam)**

Tanya became a mother at a young age (20 years old), and during Tim's first years she tried to keep him as safe as possible given the family circumstances. However, she could not stand up to his father. Tim's teacher in primary school was worried about him and arranged help. Tanya then was able to leave Tim's father and tried to start a new life with Tim. In the years to come, Tanya had a few relationships with other men, but they never lasted long. Tim's half-sister Ivy was born from one of those relationships. Tanya works hard to earn enough money to support her children, which means she is often away from home and has little control over what Tim does. The neighbor regularly helps her out by looking after Ivy.
Tanya is warm and supportive towards her children. When Tanya is home, she tries to spend as much time as possible with her children. Ivy likes this, but Tim prefers to go his own way. Tanya finds it difficult to set calm and clear limits to her children, especially when they are angry. She often finds herself in an argument with her children, and on several occasions Tim has been verbally and physically aggressive with her. At those moments, Tanya is afraid of Tim and is inclined to let him have his way to avoid conflict.

Editors

This audiovisual production was directed and produced by Marjolein van Wijk-Herbrink en Remco van der Wijngaart.

Marjolein van Wijk-Herbrink

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She edited a Dutch book on applied schema therapy in children and adolescents (Roelofs, van Wijk-Herbrink, & Boots (2020). Toegepaste schematherapie voor kinderen en adolescenten. Houten: Bohn Stafleu van Loghum). She also wrote several articles and book chapters, for an overview see: **www.psykey.nl/literatuur.**

Remco van der Wijngaart

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He is the author of, among others, the books 'Imaginary rescripting, theory and practice' (2020) and 'Chair techniques, theory and practice' (2022). In collaboration with others, he has previously produced various audiovisual learning materials, both in the field of cognitive behavioral therapy and in the field of schema therapy. For an overview of audiovisual resources, see: **www.schematherapy.nl.**

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