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Published in:
Forensic CBT: a handbook for clinical practice

DOI:
[10.1002/9781118589878.ch4](https://doi.org/10.1002/9781118589878.ch4)

[Link to publication](#)

Citation for published version (APA):
Keulen-de Vos, M., Bernstein, D. P., & Arntz, A. (2014). Schema therapy for aggressive offenders with personality disorders. In R. C. Tafrate, & D. Mitchell (Eds.), *Forensic CBT: a handbook for clinical practice* (pp. 66-83). Chichester: Wiley Blackwell. <https://doi.org/10.1002/9781118589878.ch4>

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Schema Therapy for Aggressive Offenders with Personality Disorders

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Interest in forensic treatment has increased considerably in recent years as evidenced by a growing literature on treatments for sex offenders and domestic violence offenders (e.g. Marshall & Serran, 2001; Murphy & Ting, 2010). However, the treatment of personality disordered (PD) offenders is an area in need of far greater attention. Personality disorders are highly prevalent in criminal offender populations, and are associated with increased risk of violence and recidivism (Blackburn, Logan, Donnelly, & Renwick, 2003; Leistico, Salekin, DeCoster, & Rogers, 2008). This population is traditionally considered difficult to treat. In this chapter, we describe recent developments in the application of Schema Therapy (ST; Young, Klosko, & Weishaar, 2003) to forensic patients with PDs. ST differs from other cognitive-behavioral treatments for forensic patients in several important respects. First, unlike most other cognitive-behavioral treatments, ST was specifically developed as a treatment for PDs. It is an integrative form of therapy that combines standard cognitive-behavioral interventions with other approaches that are not traditionally used in cognitive-behavior therapy, but are often necessary in working with patients with PDs. These include: (1) a focus on the therapy relationship to address the difficulties of these patients in forming secure attachments, (2) an emphasis on re-processing childhood traumas, which are highly

prevalent in this population, and (3) the use of experiential techniques that focus on emotions to remediate the affective difficulties of these patients.

Unlike other cognitive-behavioral approaches for patients with anger and aggression problems, which are often shorter-term therapies, ST is a medium- to long-term form of psychotherapy which can last for 2 to 3 years or even longer in patients with aggressive PDs, such as Antisocial, Narcissistic, or Borderline. While ST for forensic patients can be administered in therapeutic groups (Beckley & Gordon, unpublished; Farrell, Shaw & Webber, 2009; Van Vreeswijk & Broersen, 2006), it is usually delivered individually, or as a combination of individual and group therapy. In keeping with the risk, need, and responsivity principles (Andrews & Bonta, 2003), longer-term therapies are justified if they can ameliorate the risk factors for violence and recidivism in otherwise difficult-to-treat patients, such as those with PDs. In fact, such longer-term treatments may prove to be cost-effective, despite their higher costs, if they can reduce rates of incarceration and recidivism. Preliminary findings in the first 30 patients to complete an ongoing randomized clinical trial of forensic inpatients with Cluster B PDs in the Netherlands supports this contention: patients who received 3 years of ST showed greater improvement in recidivism risk, and were more likely and quicker to receive permission to enter and advance through the resocialization process that can lead to release from detention, than patients receiving usual forensic treatment. Further, the full cost of delivering ST for 3 years was fully recouped by reducing patients' length of stay in the institution by just 2 months (Bernstein, 2011). Although these findings were not yet statistically significant in this small initial sample, they suggest that the costs of delivering ST may be justified by its success in lowering recidivism risk.

In this chapter, we describe the rationale for ST, present our forensic adaptation of ST, and provide guidelines for clinical practice. The forensic ST model focuses on emotional states, known as *schema modes*, which are seen as risk factors for violence and crime. When

triggered, schema modes increase the probability of aggressive, impulsive, or other antisocial behavior. By targeting these factors, schema therapists aim to reduce the patient's risk for violence and future antisocial behavior. In our experience, and based on the preliminary results of our research, therapists can indeed learn to recognize and intervene with schema modes and work more effectively with these challenging patients.

Schema Therapy Conceptual Model

Early Maladaptive Schemas and Maladaptive Coping Responses

The ST theoretical model is based on the following core concepts: *early maladaptive schemas*, *maladaptive coping responses*, and *schema modes* (Rafaeli, Bernstein, & Young, 2011; Young, et al., 2003). Early maladaptive schemas are self-defeating themes or patterns about oneself and one's personal relationships; they refer to maladaptive cognitive structures representing the self, others, and the environment, and relations between them. Early maladaptive schemas are trait-like, enduring entities or patterns that originate from adverse childhood experiences and early temperament; they guide people's perceptions and behavior and evolve over the course of a lifetime. Over time, they become more resistant to change and give rise to negative automatic thoughts and subjective distress. For example, early maladaptive schemas such as abandonment, social isolation, defectiveness, and mistrust/abuse can evoke emotions such as fear, sadness and anger (Bernstein, Arntz, & de Vos, 2007; Jovev & Jackson, 2004). Young identified 18 early maladaptive schemas which are described in Table 1. These schemas can be grouped into five domains which are connected with certain basic childhood needs (also listed in Table 1). For example, if the need for attachment (which Young and colleagues (2003) posit to be one of 5 universal emotional needs in childhood) goes unmet to a significant degree, the result may be the development of early maladaptive schemas in the domain of "disconnection and rejection."

When early maladaptive schemas are triggered, they can give rise to strong emotions. Young and colleagues (2003) hypothesized that one can cope with the activation of such schemas in three ways: schema surrender, schema avoidance and schema overcompensation. Schema surrender means giving in to a schema in a passive, helpless, dependent, or submissive way. For example, someone with a dependence/incompetence schema may choose partners whom they perceive to be more competent than they are, on whom they rely in a “child-like” way. Schema avoidance means avoiding people or situations that might trigger a particular schema. For example, some may avoid getting involved in intimate relationships because of a profound fear or being abandoned. Finally, schema overcompensation means doing the opposite of a schema. For example, someone with a defectiveness/shame schema might behave in a denigrating way towards others, which helps them feel superior and offset feelings of inferiority.

Schema Modes

The combination of early maladaptive schemas and maladaptive coping responses constituted the original ST conceptual model, as elaborated by Young and colleagues (2003). While this model proved useful for working with most PD patients, it was inadequate for patients with more aggressive PDs. These patients often have so many early maladaptive schemas that discussing them all in therapy was unmanageable. Moreover, patients with severe PDs, such as Borderline and Narcissistic, often switch or flip rapidly from one extreme emotional state to another, making it difficult for therapists to keep track of them. Young (2003) introduced the concept of schema modes to help therapists monitor and work with these fluctuating states. Schema modes are defined as moment-to-moment emotional states that temporarily dominate a person’s thinking, feeling, and behavior. Compared to the maladaptive schemas, which are trait-like, schema modes are state-like entities. These emotional states can either be functional or maladaptive (Young, et al, 2003). We all

experience a range of emotional states. However, in people with severe PDs, these states tend to be more extreme and often involve dysfunctional forms of coping. Also, in these patients, schema modes are largely dissociated from one another: When a patient is in a particular mode, he is quite unaware of other modes. PD patients have little control over their emotional states; therefore, they rapidly switch between emotional states.

Young and colleagues (2003) distinguish 11 schema modes that cover five mode domains; others have proposed and reported evidence for additional modes (Bamelis, Renner, Heidkamp, & Arntz, 2011; Bernstein, et al., 2007; Lobbestael, van Vreeswijk, & Arntz, 2008). A complete list of modes and mode domains are listed in Table 2. *Child* schema modes involve thinking, feeling, and acting in a child-like manner; they represent emotional reactions, such as fear, sadness, loss, anger, frustration, and loneliness, which are fundamental and universal in children. *Avoidant Coping* schema modes involve attempts to block out painful emotions, and avoid people and situations which trigger them. The *Over Compensatory Coping* schema modes involve “turning the tables” on other people, and doing the opposite of schemas, to compensate for themes such as shame, loneliness, and vulnerability. The *Surrendering Coping* schema modes reflect the opposite, the tendency to submit to others in a passive, helpless, or dependent way. The *Maladaptive Parent* schema modes relate to self-directed punishment or criticism, or self-directed pressure to perform, respectively, and reflect internalized dysfunctional behavior of the parent (or other caregivers) directed towards the child. Finally, the *Healthy* schema modes express healthy, balanced, self-reflection and feelings of pleasure, spontaneous playfulness, and joy, respectively (Rafaeli, et al., 2011; Young, et al., 2003).

Not all schema modes are relevant for each patient. According to ST, distinctive schema mode configurations or combinations of modes are believed to be markers of specific personality disorder pathology. For example, Borderline PD (BPD) is hypothesized to be

centered around four dominant schema modes: (1) *Abused /Abandoned Child* mode, marked by feelings of abandonment or abuse, (2) *Angry/Impulsive Child* mode, characterized by uncontrolled anger or rage in response to perceived abandonment or maltreatment and rebellious impulsive need satisfaction, (3) *Punitive/Critical Parent* mode, marked by self-punitive behavior, and (4) *Detached Protector* mode, which includes feelings of detachment (Arntz & van Genderen, 2009; Young, et al., 2003).

Related to the focus of the present chapter, the schema modes relevant for Narcissistic PD (NPD) and Antisocial PD are described. NPD is hypothesized to be centered around four modes: (1) *Self-Aggrandizer* mode, which includes the themes of grandiosity, entitlement and self-importance, (2) *Lonely/Inferior Child* mode, that includes feelings of loneliness or emptiness or inferiority, (3) *Detached Self-Soother* mode, which leads to coping by self-soothing behavior such as drug and alcohol use, and (4) *Enraged Child* mode, expressing rage often towards the person who triggered these poorly tolerated feelings (Behary, 2008; Bamelis, et al., 2011; Young & Flanagan, 1998).

Bernstein and colleagues (2007) hypothesized that antisocial and especially psychopathic offenders make prominent use of several *forensic schema modes*, as well as other modes involving overcompensation (e.g. *Self-Aggrandizer* and *Bully and Attack* modes). For example, psychopaths' crimes often include: (1) *Predator* mode, which involves cold and ruthless aggression, (2) *Conning and Manipulative mode*, marked by deceit, and (3) *Bully and Attack* mode, which involves aggression to assert dominance. These modes are believed to have been developed during childhood under conditions of extreme threats and humiliation (Jaffee, Caspi, Moffitt, & Taylor, 2004; Poythress, Skeem, & Lilienfeld, 2006) and they serve as a shield to protect corresponding feelings of vulnerability, anger, and frustration (Bernstein, et al., 2007). Recent research supports the contention that

specific configurations of modes characterize different PDs (Bamelis, et al., 2011; Lobbestael, et al., 2008).

Schema Therapy: Forensic Adaptation

There are several important adaptations to treatment that may be required when working with forensic patients. First, issues like violence and deception are far more prominent in forensic patients as compared to those in general psychiatric settings (Bernstein, et al., 2007). Therapists may easily feel frightened by the potential for violence. Second, the circumstances and settings in which forensic patients are treated present special challenges which are not often seen in general psychiatry. Forensic patients are sentenced to treatment, which means that their admission is involuntary in nature. This can affect motivation and compliance with treatment, and can set up a dynamic of opposition and mistrust (Sainsbury, Krishnan, & Evans, 2004). It can also affect the therapist's motivation for providing treatment. Therapists may feel frustrated by a patient's lack of progress, or become suspicious of their motives. These issues may affect the therapeutic alliance, an aspect that has a significant influence on therapy outcome (Marshall & Seran, 2004; Ross, Polaschek, & Ward, 2008). Third, offenders have relatively limited choices regarding their treatment team; moreover, the team is also responsible for safety of the patient and his surroundings (McCann, Ball & Ivanoff, 2000). This may complicate patients' interactions with staff members. For example, too much attention to risk and safety issues can undermine and possibly preclude effective treatment (Norton & McGauley, 2000), while too little can also create problems.

For these reasons, we found it necessary to adapt ST to forensic settings. First, we expanded the schema mode model by adding modes that are prevalent in forensic patients, but seldom seen in general psychiatric settings. Moreover, we conceptualized these "forensic" modes as psychological risk factors for crime and violence. When these modes are

triggered, they increase the probability of aggressive, impulsive, or other antisocial behavior. Thus, forensic ST focuses on ameliorating the psychological risk factors that, when triggered, can lead to criminal or violent recidivism.

As listed in Table 2, we added five schema modes to Young's original mode model: the Angry Protector, Conning and Manipulative, Predator, and two Over-Controller modes (*Obsessive* and *Paranoid* subtypes). As an exercise, see if you can match these forensic schema modes in Box 1 to case examples presented in Box 2. Answers are provided in Box 5.

Box 1: Forensic Schema Modes

- (a) Angry Protector mode is an emotional state of controlled anger or hostility, a “wall of anger” which serves to keep people at a safe distance.
- (b) Predator mode is a state of cold, ruthless aggression; the focus is on eliminating a threat, obstacle, or enemy, which is carried out in a callous, unfeeling and often unplanned manner.
- (c) Conning and Manipulative mode is a state involving conning, lying and manipulating others in order to achieve a specific goal, such as escaping punishment or victimizing others for some type of gain (e.g., material, sexual).
- (d) Over-Controller mode involves excessive control and a focusing of attention on a real or perceived threat or danger. In the *Obsessive-Compulsive* subtype, also called the *Perfectionistic Overcontroller*, the patient attempts to exercise control through the use of order, repetition, or ritual. In the *Paranoid* subtype, the patient attempts to seek out and therefore control a source of danger or humiliation, usually by locating and uncovering a hidden (perceived) threat (Bernstein, et al, 2007).

Box 2: Case Examples

- (1) Mike discovered another man in his bed with his girlfriend. The man escaped from the house, but the girlfriend stayed behind. Mike had known for a while that his girlfriend was unfaithful to him. He confronted her, but she denied it. A cold rage took over him. He decided to kill her as retaliation for her infidelity.
- (2) Stephen was abused by his father when he was a child. He always keeps close track of everyone, and trusts no one except his mother. He refuses to do things he cannot control. In ST, he refused to do imagery practices, stating that he didn't want to close his eyes.
- (3) Kevin sexually offended against a child, and was sentenced to treatment in a forensic hospital. He learned that his unsupervised leave was denied, because the 'leave committee' found it unclear whether he still had sexual fantasies about children. When his psychotherapist brought up this topic, Kevin became very irritated. He said that it was obvious that no one believed him, and refused to discuss the topic further.
- (4) Bill was sentenced to prison for raping his girlfriend multiple times. During psychotherapy he fell in love with his female therapist. He repeatedly tried to tempt her to step out of her therapist-role by asking her direct, personal questions (e.g., Are you in love with me,?, Do you have kids? What type of men do you like?). When the therapist told him that she is not in love with him but respected him as a person, he twisted this information and tried to use it against her by telling the nursing staff that she was in love with him and that they had a romantic relationship.

Clinical Practice

ST integrates techniques from various approaches, such as cognitive, behavioral, psychodynamic and emotion-focused therapies. The initial phase of therapy is focused on assessment, education and building a therapeutic relationship between patient and therapist. This phase concludes in an individual case conceptualization which is used as a guideline for the treatment.

Assessment and Case Conceptualization

The therapist evaluates the patient's suitability for ST. Although ST was originally developed for PD patients and patients with other longstanding problems, psychiatric co-morbidity with Axis I disorders and coinciding psychotropic medication are not an exclusionary criterion for ST. However, there are some co-morbid conditions that may be a contraindication for ST, such as low intelligence ($IQ < 80$), neurological impairments, autistic spectrum disorders and certain psychotic disorders. The presence of such conditions may require modifications in standard ST techniques (e.g., avoiding using emotion-focused techniques in patients who are vulnerable to psychotic decompensation), or may suggest that other forms of therapy are indicated rather than ST.

We do not consider high levels of psychopathic traits as an exclusionary criterion for ST. Although it is commonly believed that psychopathic patients are untreatable, or that treatment actually makes them worse, there is little empirical support for this view (D'Silva, Duggan, & McCarthy, 2004). Recent studies suggest that some psychopathic patients may benefit from psychotherapy (Chakhssi, de Ruiter, & Bernstein, 2010; Skeem, Monahan, & Mulvey, 2002), a position that is consistent with our own clinical experiences, as well as the preliminary findings of our research (Bernstein, 2011). Psychopathic patients do require attention to issues such as dominance, manipulation, and deception, which can arise in the therapy relationship; some adjustments in the therapist's technique are therefore necessary.

Nevertheless, our experiences working with these patients lead us to be optimistic that some may be helped by treatment, a view that also needs to be tempered with realism about the challenges posed by these patients.

As with all CBT-oriented treatments, careful diagnosis and assessment are an essential prerequisite for ST. The therapist begins with an initial evaluation and assesses the patient's presenting problems and goals for therapy by taking a life history and gathering information from multiple sources, including administering questionnaires, reviewing the available records, and observing the patient's behavior and emotional states. The therapist explains the ST model and schema mode language, and asks the patient to fill out certain questionnaires, such as the *Schema Mode Inventory* (SMI; Young, et al., 2007) and *Young Schema Questionnaire* (YSQ; Young & Brown, 2003).

Because responses to these self-report questionnaires are often limited by a lack of patient insight (Keulen-de Vos, Bernstein, Clark, Arntz, Lucker, & de Spa, 2011; Lobbestael, Arntz, Löbbs, & Cima, 2009), the therapist also uses experiential techniques, such as imagery, to trigger schema modes. The therapist observes the patient's schemas and coping responses as they manifest themselves in the therapy sessions. Available records are then used to identify dysfunctional life patterns, using the ST conceptual model to link them to presenting problems. Relevant schema modes are identified and conceptualized in an individual case conceptualization form. These formulations are the initial focus of the treatment (Rafaeli, et al., 2011; Young, et al., 2003). Case conceptualizations not only guide therapeutic interventions, they are also helpful in educating patients about their problems. Furthermore, case conceptualizations are not static, but can change as the treatment progresses. For example, new information and insights may call for re-adjustments of the initial case conceptualization.

The case conceptualization is based primarily on schema modes, rather than early maladaptive schemas, because they reflect the combinations of certain early maladaptive schemas and maladaptive coping responses. Also, forensic patients often have so many early maladaptive schemas that discussing them all would be unmanageable. It is important to use a conceptual framework that is relatively clear, simple, and consistent. In forensic patients, schema modes serve this purpose because they describe problematic emotional states and behaviors in a manner that is straightforward, is easy for patients to understand, and gives therapists clear targets for interventions. Early maladaptive schemas and coping responses may also be examined, but are secondary to schema modes in working with forensic patients.

The case conceptualization, which is individualized for each patient, is usually represented visually, in the form of a diagram. This is illustrated in Figures 1a and 1b, for a hypothetical psychopathic patient, and a narcissistic patient, respectively. The maladaptive coping modes are shown in the middle and left side of the figure, while the maladaptive child and parent modes are presented on the right side. The adaptive modes are shown above the dashed line. This visual representation makes the patient's modes easier to grasp for both therapist and patient. A simplified version is often shared with patients, and can be kept on hand during sessions, so it can be referred to when needed.

In forensic ST, the explication of the patient's crimes are an important part of the case conceptualization process (Bernstein, de Jonge, & Jonkers, 2011). In fact, a clear understanding of the patient's criminal behaviors are a prerequisite for forensic treatment. 'Crime scenarios,' that is, the events leading up to and culminating in criminal or violent behaviors can often be reconstructed in terms of an unfolding sequence of schema modes (Bernstein et al., 2007, 2011). The case conceptualization aims to clarify these sequences: What kinds of violent behavior were displayed, what triggered them, what emotions and cognitions accompanied them, what were the motivations behind them, and what were their

consequences? These factors are conceptualized as schema modes; the amelioration of these modes, with the goal of reducing the risk of future offending, becomes a central goal of the therapy. During the case conceptualization phase, the therapist makes prominent use of patient records in reconstructing these sequences, and the role that modes play in them, because patients may be reluctant to share certain information (e.g. details about crimes, abuse histories) in this early phase of therapy.

Treatment Strategies

Cognitive and behavioral techniques. Schema modes reflect underlying early maladaptive schemas, maladaptive coping responses and emotional states. Therefore, ST aims to produce change at different levels: problematic schemas need to be disputed, painful emotions to be worked through, and problematic behavior to be altered, whereas new, healthier patterns of thinking, feelings, and behaving are to be reinforced. ST uses a variety of interventions to achieve change. Cognitive interventions are used to modify patient's ways of thinking and educate patients about their unmet needs, schemas, and maladaptive coping responses (Kellogg & Young, 2006). As long as patients believe strongly in the legitimacy of certain schemas, change cannot occur. Together, patient and therapist gather evidence of pros and cons of certain schemas and coping responses. Therapists typically use cognitive techniques such as flashcards and schema diaries to increase awareness of schemas. For example, flashcards contain concise statements summarizing the evidence against the patient's schemas (Young, et al., 2003). By using cognitive strategies, patients learn that, at least on an intellectual level, their underlying schemas are distorted and learn to view themselves and others in more balanced, realistic ways. Behavioral techniques are used to help patients practice new behaviors and gain confidence in consolidating behavioral change. Schema therapists can incorporate a variety of standard cognitive-behavioral techniques into their work, such as exposure, anger management, assertiveness training and relaxation.

Experiential techniques. While traditional cognitive-behavioral techniques can play an important role in working with forensic patients, our experience suggests that they are not, in themselves, sufficient, to produce deeper or more lasting change in many forensic patients with PDs. Many of these patients are highly detached from their emotions (Murphy & Vess, 2003). Cognitive therapy methods are predicated on the idea that changing thoughts leads to changes in emotions. However, detachment from emotions can render these techniques ineffective. Research suggests that “hot” cognitions – that is, cognitions that are accompanied by emotional arousal – are easier to change than “cold” ones (David & Szentagotai, 2006, Holmes & Mathews, 2005). Thus, simply talking about emotions, when this is done in a highly intellectualized or emotionally distant way, is usually insufficient to produce emotional change. ST makes prominent use of experiential techniques in order to bring emotions into active awareness and overcome emotional distance (Leahy, 2007; Mennin & Farach, 2007; Warwar, Links, Greenberg, & Bergmans, 2008). In fact, experiential, or emotion-focused, techniques are one of the hallmarks of ST, which distinguish it from more traditional cognitive-behavioral therapy approaches. Thus, while cognitive interventions lay the groundwork for awareness and insight in unhealthy schemas and modes, experiential techniques aim to consolidate this awareness on a deeper, emotional level. Moreover, forensic ST places even greater emphasis on emotion-focused techniques than is usually the case with non-forensic patients, because forensic patients are so highly detached.

Two experiential techniques in ST that are commonly used are chair-work and imagery re-scripting. In chair-work, the patient switches between chairs and is invited to have dialogues between different parts of the self (Kellogg, 2004; Paivio & Greenberg, 1995). The patient sits in one chair when he plays a certain mode and switches chairs when a different mode is addressed or becomes active. Chair-work, which was borrowed by ST from Gestalt

Therapy and Drama Therapy, makes patients' schema modes more tangible, helping them to "feel" the mode that they are playing. The therapist can enact real scenes from the past or present, or make up scenes, "re-script" scenes to make them turn out differently, and have the patient use role playing to practice healthier attitudes and coping responses.

Imagery re-scripting is a technique in which the therapist asks the patient to visualize an upsetting childhood memory or traumatic image from the past or present. The patient explores key images that are related to unmet early developmental needs, such as the need for closeness and connection, protection, the validation of feelings, and so forth. Next, the therapist intervenes in the upsetting memories by re-scripting or changing the course of the original situation. A positive atmosphere is created in which the emotional needs of the patient are met in a healthy way, instead of being ignored or violated. As a result, the patient feels safer and more in control of the situation, and the underlying schemas that have been triggered via the imagery can begin to heal, as his early emotional wounds are re-processed. The patient also begins to understand the links between the past and his present situation, which he can feel in a vivid and immediate way (Arntz, 2011; Rafaeli, et al., 2011; Smucker & Boos, 2005). Box 3 contains a clinical example of this technique.

Box 3: A Case Example Involving the Use of Imagery and Rescripting

Paul, a highly psychopathic patient, had refused to do imagery exercises for the first two years of his therapy. Finally, he agreed to do so. He closed his eyes, and brought an image to mind of having been sadistically beaten by his father, a common occurrence in his household growing up. This time, however, when he was 14 years old he “turned the tables” on his father, taking him by surprise and savagely beating him. This imagery exercise represented a turning point in the therapy, helping the patient to make emotional contact with the side of him that lived in terror of his father (Abused Child mode), and to recognize that he had learned to over-compensate for his fear by taking the upper hand, which usually involved aggressing against others before they could do the same to him (Bully and Attack mode).

In subsequent imagery sessions, the patient and therapist revisited these episodes, with the therapist "rescripting" the scene to protect the child and confront the abuser. In these sessions, the therapist asked the patient's permission to "enter" the image to provide for the child's needs, such as safety, comfort, and validation. In one instance, the patient and therapist arranged to have the police come to take the father away and lock him up, where he couldn't hurt the child anymore. In another session, the patient vented his anger at the father, with his therapist's support. Over a series of 5 of these sessions, spread over a period of several weeks, the patient gained greater freedom from the terrorizing image of his father, which he had carried with him his whole life. He reported feeling calmer, safer, and being less emotionally triggered in situations where he had previously responded with aggression.

Therapeutic Style

The basic therapeutic style in ST is known as *limited reparenting*, because the therapist provides for some of the patients' early unmet developmental needs, within reasonable limits and boundaries. Limited reparenting means that the therapist acts like a "good enough" parent for the patient; he provides some of what the patient missed, in appropriate ways. For example, the therapist might provide warmth, empathy, recognition and validation of emotions, or empathic confrontation and limit setting, depending on the patient's unmet emotional needs. This therapeutic style is another feature that sets ST apart from other CBT-oriented therapies.

Limited reparenting is truly at the heart of ST. It is a defining feature of the therapy because it is incorporated into how the therapist interacts with the patient, as well as the way interventions and techniques are applied. For example, when imagery exercises involve a patient being abused as a child, the therapist uses rescripting to protect the child, to meet the need for safety that had been unfulfilled in the patient's childhood.

For limited reparenting to succeed, the therapist needs to be able to reach the patient's vulnerable side. However, forensic patients are often difficult to reach emotionally. Many of them have been exposed to violence, or have been abandoned or abused, and therefore have never experienced interpersonal relationships based on reciprocal trust and validation. These patients typically come across in therapy sessions as hostile, mistrustful and detached. It takes time for the patient to develop a trusting relationship with the therapist; it is not at all uncommon for it to take a year or more for these patients to form an attachment to the therapist. In addition to being patient and persistent, the therapist needs to be flexible, because basic emotional needs may differ from patient to patient, and may vary within a given patient from one session to another.

Empathic Confrontation and Limit Setting

In order to access the patient's vulnerable side, the therapist needs to empathically confront, and at times, set limits on, the patient's maladaptive coping modes, which block access to it. In *empathic confrontation*, the therapist starts by acknowledging and validating the patient's maladaptive coping modes; he calls the patient's attention to the modes ("I wonder which side of you this is?") and explores the functions that they serve in an accepting and non-judgmental manner. The therapist then gently points out the maladaptive consequences of the modes, and thus stresses the necessity for change (Young, et al., 2003). Sometimes, the therapist can use role-play and role-reversal as additional tools to help the patient to recognize the modes and understand their functions.

In *limit setting*, the therapist enforces limits on the patient's maladaptive modes in a clear, firm, and consequential, but non-punitive, manner. Rather than setting limits by making reference to impersonal rules ("Clinic policy states that patients can't be late for sessions"), the therapist does so in a personal way, using self-disclosure where appropriate ("I notice that I'm getting frustrated with your coming late so often. I want to work with you, but not in this way."). Limit setting is used whenever the patient engages in behavior that is destructive to himself or other people, is disrespectful or transgresses boundaries, or undermines the therapy (e.g., by coming repeatedly late to sessions or missing appointments). This empathic and morally neutral approach to confronting and setting limits is especially important, because forensic patients often experience confrontation and limits as punitive, arbitrary, or unfair. In our experience, the vast majority of forensic patients respond well to these interventions, when the therapist is clear and firm, but also compassionate. Box 4 provides a clinical example of the use of limited reparenting, empathic confrontation, and limit setting.

Box 4: Case Example Involving Use of Limited Reparenting, Empathic Confrontation, and Limit Setting

Brian, an antisocial patient, was distant, hostile, and mistrustful throughout the first 6 months of the therapy. His therapist tried to remain interested, warm, and attentive, but became discouraged by the lack of progress. Eventually, she confronted him, but in an empathic way, stating that she understood the reasons for his mistrust, but that she was becoming discouraged by it. She said that she couldn't go further with him unless he was willing to take some risks to open up with her. The therapist's use of limit setting, done in a firm but caring way that also involved appropriate self-disclosure of feelings, was effective. The patient, while initially surprised, agreed to share more openly with her. Their relationship grew warmer and more comfortable, though he remained quite guarded at times. Over time, the therapists' warmth, availability, and consistency, as well as her willingness to confront the patient in a direct but non-judgmental way, helped to counteract the patient's mistrust. Eventually, he learned to rely on her for help and advice in handling difficult situations. He received permission to go on leave, and

Treatment Motivation

In the forensic field, motivation for treatment is often considered a necessary prerequisite for starting treatment. However, forensic patients' motivation and readiness to engage in therapy is typically low (Sainsbury, et al., 2004). In these cases, patients may be given short-term interventions, such as motivational interventions, to prepare them for more intensive forms of therapy. Patients who don't respond to these kinds of interventions, or who repeatedly resist efforts to engage them, are often considered "untreatable," and denied further treatment.

ST views treatment motivation as dynamic and fluctuating, rather than static and unchangeable. Furthermore, ST conceptualizes motivation and engagement in terms of schema modes that block therapeutic progress. By working with modes, ST seeks to enhance patients' motivation, a process that may be necessary over the entire course of the therapy. Various modes may interfere with patients' ability to engage in treatment. For example, the Detached Protector ("I have no feelings."), Self-Aggrandizer ("I don't have any problems."), and Paranoid Overcontroller ("I don't trust anyone.") modes can block patients' motivation. The goal is to work with these different schema modes so that the patient is gradually invited to switch into modes that are more productive, such as the Vulnerable Child and Healthy Adult modes, in which patients are more in touch with their underlying feelings.

Pitfalls and Recommendations

Limits and Boundaries

Schema Therapy requires that therapists are willing to be accessible and emotionally available to their patients, and to foster an attachment relationship with them. Furthermore, because ST is a moderate to long-term treatment, therapists must be prepared for a longer-term commitment. A common pitfall for therapists is that they are too distant or cool towards

the patients, or overly critical when a patient doesn't improve quickly enough (Arntz & van Genderen, 2009; Young, et al., 2003). On the other hand, some therapists have "loose" boundaries, and self-disclose or engage in other inappropriate behavior. An important *modus operandi* in ST should be that the therapist strikes a balance between being too close or too distant, thus having "permeable boundaries" – that is, boundaries that are firm but flexible enough to provide closeness within appropriate limits.

This pitfall is closely related to another one, namely difficulties with limit setting. Therapists need to set appropriate limits on patients' destructive and self-destructive behaviors (Arntz & van Genderen, 2009; Young, et al., 2003). However, some therapists are reluctant to set limits out of fear of provoking a negative reaction; thus, they allow self-defeating, devaluing, or aggressive behavior to go on for too long. Other therapists may set too firm limits because they are too overwhelmed by the intensity of their patient's emotions or too afraid of their intimidating behavior (Young, et al., 2003). Again, it is very important that therapists learn to set limits in a timely and firm, but non-punitive manner.

Forensic patients pose specific challenges for their therapists that are less often seen outside of the forensic field. For example, many narcissistic offenders have a strong Self-Aggrandizer mode, in which they behave in a devaluing and arrogant manner towards their therapists. Other offenders attempt to manipulate or deceive their therapists. For example, some forensic PD patients deliberately withhold information or respond in a socially desirable manner and present an unduly positive image of themselves; others may malingering (i.e., fake) symptoms (Keulen-de Vos, et al., 2011). The schema mode model provides a means for therapists to recognize and intervene effectively when patients engage in these and other challenging behaviors.

Requirements for Therapists

ST is a complex form of therapy that requires specialized training and supervision. This is especially so in the forensic field, where patients are so challenging. We recommend that therapists have 3 years of prior psychotherapy experience before they attempt to master ST (Bernstein, et al., 2007). Therapists should seek training in ST through a program that is accredited by the International Society for Schema Therapy (ISST). These programs have requirements including several training days with a standardized curriculum, supervision by certified Schema Therapists, and competency ratings by independent experts. Even after receiving certification, we recommend that therapists working with forensic patients continue to receive supervision or peer-supervision on their cases. In our experience, the ongoing support and feedback one receives in supervision is critical to achieving success in the face of the ongoing challenges that these patients present.

In the forensic field, quality assurance in the delivery of treatment is essential. Even more than in most other areas of mental health practice, a lack of adherence to the principles and practices of evidence-supported treatments can have serious consequences, when patients relapse to crime and violence. The investment in training therapists to work effectively in the forensic field is one that is likely to be repaid in the benefits it yields --, not only in terms of improving the lives of patients, but in reducing the damage to lives and property, and the enormous financial costs of incarceration related to antisocial behavior.

Box 5: Answers for Matching Forensic Schema Modes to Case Examples

a = 3; b = 1; c = 4; d = 2

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Table 1

Schema Domains and Early Maladaptive Schemas

Domain: Disconnection and Rejection

Early Maladaptive Schemas:

1	Abandonment/Instability	The expectation that one will inevitably be abandoned
2	Mistrust/Abuse	The expectation that others will hurt, abuse, humiliate, cheat, lie, manipulate, or take advantage
3	Emotional Deprivation	The expectation that others won't meet one's need for a normal degree of emotional nurturance, empathy, and protection
4	Defectiveness/Shame	The feeling that one is defective, bad, unwanted, inferior, or invalid in important respects.
5	Social Isolation/Alienation	The feeling that one is always an outsider, different and alienated from other people

Domain: Impaired Autonomy and Performance

Early Maladaptive Schemas:

6	Dependence/Incompetence	Expectation that one can't handle everyday responsibilities without considerable help from others.
7	Vulnerability to Harm or Illness	Exaggerated fear that imminent catastrophe will strike at any time and that one cannot prevent it.
8	Enmeshment/Undeveloped Self	Excessive emotional involvement and closeness with others at the expense of full individuation or normal social development.
9	Failure	The belief that one has failed, or will inevitably fail, or is fundamentally inadequate in areas of achievement

Domain: Impaired Limits

Early Maladaptive Schemas:

10	Entitlement/Grandiosity	The belief that one is superior to others, entitled to special rights and privileges, or bound not by normal rules of social reciprocity
11	Insufficient Self-Control/Self-	Pervasive difficulty or refusal to exercise self-control and

Discipline	frustration tolerance to achieve goals.
<i>Domain: Other-Directedness</i>	
<i>Early Maladaptive Schemas</i>	
12 Subjugation	Excessive surrendering of control to others because one feels coerced, to avoid anger, retaliation, or abandonment
13 Self-Sacrifice	Excessive focus on voluntarily meeting the needs of others at the expense of one's own gratification.
14 Approval-Seeking/Recognition-Seeking	Excessive emphasis on gaining approval, recognition, or attention from other people
<i>Domain: Over-Vigilance and Inhibition</i>	
<i>Early Maladaptive Schemas</i>	
15 Negativity/Pessimism	A pervasive, lifelong focus on the negative aspects of life (e.g., pain, death, loss) while minimizing the positive or optimistic aspects
16 Emotional Inhibition	The excessive inhibition of spontaneous action, feeling, or communication
17 Unrelenting Standards/Hypercriticalness	The belief that one must strive to meet very high internalized standards of behavior and performance
18 Punitiveness	The belief that people should be harshly punished for making mistakes

Note: Adapted from Young, Klosko, & Weishaar, 2003.

Table 2

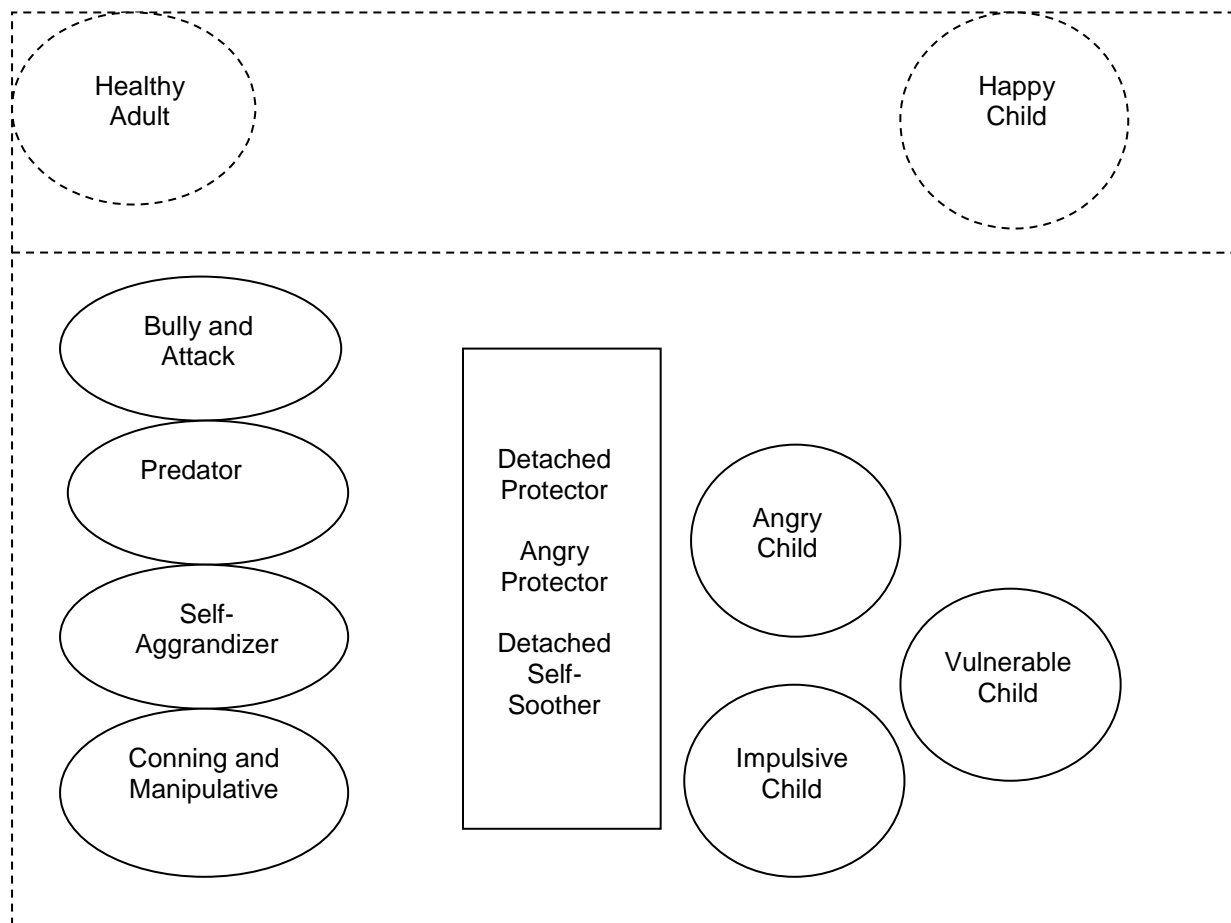
Schema Modes

<i>Child Modes</i>	<i>Involve feeling, thinking, and acting in a “child-like” manner</i>
1. Abandoned/Abused Child	Feels vulnerable, overwhelmed with painful feelings, such as anxiety, depression, grief, or shame/humiliation.
2. Angry Child	Feels and expresses anger in an excessive way in response to perceived or real mistreatment, abandonment, humiliation, or frustration; often feels a sense of being treated unjustly; acts like a child throwing a temper tantrum.
3. Enraged Child	Feels and acts enraged for similar reasons as Angry Child, but loses control over aggression and attacks and destroys objects and humans. Patients often report as if they went into a dissociative state (“everything went black”)
5. Impulsive Child	Acts impulsively to get needs met. Can be motivated by rebelliousness against maltreatment or against internalized parental modes.
6. Undisciplined Child	Acts like a spoiled child who “wants what he wants when he wants it”, and doesn’t want to do anything he dislikes. Can’t tolerate the frustration of limits and discipline.
7. Lonely Child	Feels lonely and empty, as if no one can understand him, soothe or comfort him, or make contact with him.
<i>Dysfunctional Coping Modes</i>	<i>Involve attempts to protect the self from pain through maladaptive forms of coping</i>
8. Detached Protector	Uses emotional detachment to protect one from painful feelings; is unaware of his feelings, feels “nothing,” appears emotional distant, flat, or robotic; avoids getting close to other people
9. Detached Self-Soother/Self-Stimulator	Uses repetitive, “addictive,” or compulsive behaviors, or self-stimulating behaviors to calm and soothe oneself; uses pleasurable or exciting sensations to distance oneself from painful feelings.
10. Compliant Surrenderer	Gives in to the real or perceived demands or expectations of other people in an anxious attempt to avoid pain or to get one’s needs met; anxiously surrenders to the demands of others who are perceived as more powerful than oneself.
11. Angry Protector	Uses a “wall of anger” to protect oneself from others who are perceived as threatening; keeps others at a safe distance through displays of anger; anger is more controlled than in Angry Child Mode
<i>Maladaptive Parent Modes</i>	<i>Involve internalized dysfunctional parent “voices”</i>
12. Punitive, Critical Parent	Internalized, critical or punishing parent voice; directs harsh criticism towards the self; induces feelings of shame or guilt
13. Demanding Parent	Directs impossibly high demands toward the self; pushes the self to do more, achieve more, never be satisfied with oneself.
<i>Over-Compensatory Modes</i>	<i>Involve extreme attempts to compensate for feelings of shame, loneliness, or vulnerability</i>
14. Self-Aggrandizer Mode	Feels superior, special, or powerful; looks down on others; sees the world in terms of “top dog” and “bottom dog;” shows off or

- acts in a self-important, self-aggrandizing manner; concerned about appearances rather than feelings or real contact with others
15. Bully and Attack Mode
Uses threats, intimidation, aggression, or coercion to get what he wants, including retaliating against others, or asserting ones dominant position; feels a sense of sadistic pleasure in attacking others
 16. Conning and Manipulative Mode
Cons, lies, or manipulates in a manner designed to achieve a specific goal, which either involves victimizing others or escaping punishment
 17. Predator Mode
Focuses on eliminating a threat, rival, obstacle, or enemy in a cold, ruthless, and calculating manner.
 18. Obsessive compulsive Over-Controller Mode
The Obsessive type (sometimes called “Perfectionistic Overcontroller”) attempts to protect oneself from a perceived or real threat by focusing attention, ruminating, exercising extreme control, and using order, repetition, or rituals.
 19. Paranoid Overcontroller Mode
Attempts to protect oneself from a perceived or real threat by focusing attention, ruminating, and exercising extreme control. The Suspicious type attempts to locate and uncover a hidden (perceived) threat.

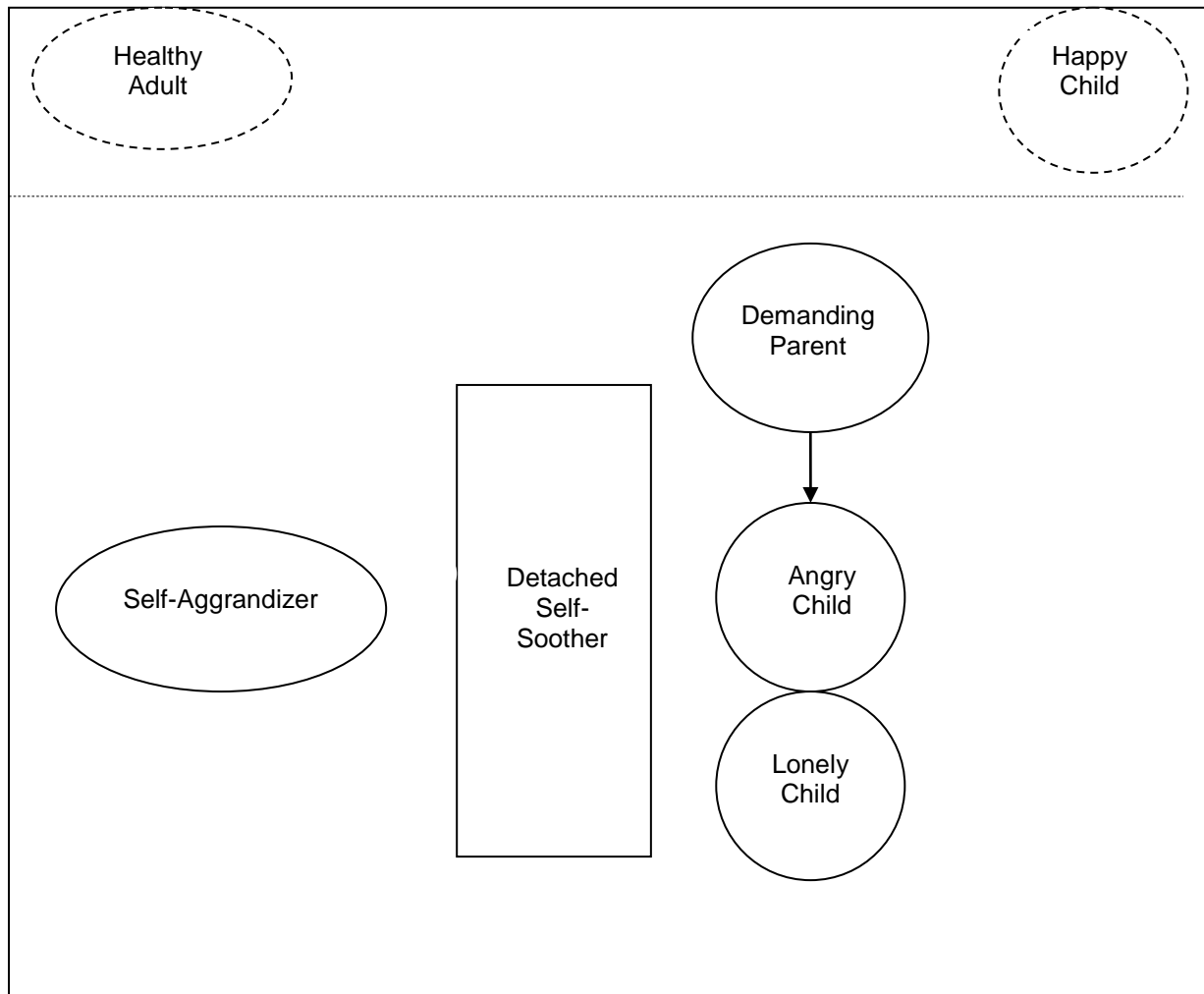
Note. Modes 1-2, 5-10, 12-14, are adapted from Young, Klosko, & Weishaar, 2003.

Figure 1a. Example case conceptualization in a psychopathic patient.



Note. Overcompensating modes on the left (in the ovals), avoidant coping modes in the middle (in the rectangle), and child and parent modes on the right (in the circles), healthy modes, if applicable, in the dashed lines.

Figure 1b. Example case conceptualization in a narcissistic patient.



Note. Overcompensating modes on the left (in the ovals), avoidant coping modes in the middle (in the rectangle), and child and parent modes on the right (in the circles), healthy modes, if applicable, in the dashed lines.