SCHEMA THERAPY BULLETIN

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International Society of Schema Therapy

Welcome to the Winter Edition of the ISST Bulletin!

In this issue, schema therapists working with forensic populations discuss their clinical work applying schema therapy to these challenging patients.


Dr. Bernstein and **Ms. Navot** begin with an overview of their extensive work using forensic schema therapy (FST). They outline seven key aspects of what makes FST different from traditional ST, including the focus on extreme emotional states, the extra time needed to build a trusting relationship, the difficulties motivating patients, and more.

Dr. Madsen uses a case study to demonstrate applying ST to his forensic patient, Jon, and salient aspects of his work with Jon over 5 years. With ST Jon (who spent most of his life in prison and has a strong propensity to intimidate others) begins to understand his aggression in mode terms, experience healthy vulnerability, and express a desire for connection with others.


Dr. Eigner and **Dr. Nedoma** integrate ST with psychoanalytic theory to explore the role language and semiotics play in treating forensic patients. They introduce us to a young man in prison for life who struggles to find a language to grasp the enormity of his actions. ST, unlike the "moralizing" modalities often used in forensic work, will enable him to accept what he has done in a manner that integrates with other, healthier all parts of his being.

Dr. Hernández-Morales addresses applying ST to dual-disorders - specifically co-occurring mental health and substance use disorders that often appear in forensic patients. He explains ways to use ST to help these patients address the schema-modes influencing substance use.



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WHAT MAKES FORENSIC SCHEMA THERAPY DIFFERENT? THE WORLD AT THREE STANDARD DEVIATIONS BEYOND THE MEAN

INTRODUCTION

It is difficult to convey to people who have never worked in forensic settings how different it is from general mental health care.[1] The metaphor that we like to use is that forensic mental health care is like experiencing the world from three standard deviations beyond the mean . It is on a continuum with whatever you have experienced in your own general psychology practice, but far more extreme.

Let's take an example. We know that lying is common in daily life. Some studies suggest that the average person lies one to two times per day. Most of these lies are of the small, harmless variety. In general psychology practice, most lies you encounter will be ones of distortion or omission. These are the things that your patients minimize, or choose not to tell you. Sometimes they are embarrassed, or afraid of being judged. At other times they hold onto information to keep their sense of autonomy.

What about in forensic care? Consider the following scenario. You may find yourself convinced by a patient's story about why he needs a favor from you, something urgent and compelling. Only after you've done the favor does it suddenly occur to you that he has gotten you to cross a boundary, for example, break a rule or even put yourself in jeopardy. You ask yourself, "How could I have allowed this to happen?" His lies have smoothed the path that you have unwittingly taken. Welcome to life at three standard deviations beyond the mean.

Because life at three standard deviations beyond the mean is different, forensic schema therapy (FST) has to be different, too. We need to adapt schema therapy to the challenges of working with patients who lie, charm, and manipulate, threaten and dominate, have explosive, angry outbursts, or keep us at a wary, hostile distance. We need to take into account the fact that forensic treatment is often involuntary, and the settings in which treatment takes place, for example, closed institutions like forensic hospitals and prisons, severely restrict one's freedom. We need to factor in our own emotional reactions when we work with patients who exhibit extreme and sometimes violent behavior.

[1] In a normal distribution, these are things that happen less than 0.15% of the time.

We have accumulated a vast amount of experience in what works and doesn't work in FST, since it was introduced by Dr. David Bernstein and colleagues in 2007 (Bernstein et al., 2007). The successful results of a major randomized clinical trial in the Netherlands (Bernstein et al., 2021) provide compelling evidence supporting these concepts. Over the past nearly twenty years, these efforts have challenged the prevailing view that antisocial patients, particularly those with high levels of psychopathy, cannot be treated (Bernstein et al., 2021; Chakhssi et al., 2014).

SEVEN KEY ASPECTS THAT MAKE FST DIFFERENT

In this article, we summarize seven key aspects that make FST different, and how we need to adapt our schema therapy practice accordingly.

1. FST HAS TO FOCUS ON THE EXTREME EMOTIONAL STATES ("MODES") THAT ARE COMMON IN FORENSIC SETTINGS, BUT FAR LESS IN GENERAL PRACTICE.

Modes are emotional states combining feelings, thoughts, and coping responses that dominate a person's functioning at a given moment. Modes that involve extreme attempts at overcompensation are what most differentiate forensic from non-forensic patients. In forensic practice, modes involving suspicious hyper-alertness (Paranoid Overcontroller mode), hostile distance (Angry Protector mode), dominance (Self-Aggrandizer mode), lies and manipulation (Conning Manipulator mode), and both subtle and overt threats and aggression (Bully and Attack mode), are nearly every day occurrences (Bernstein et al., 2019; Bernstein & Navot, 2020; Chakhssi et al., 2014; Keulen-de Vos et al., 2017). Cold, ruthless aggression (Predator mode), although less common, can be highly destructive when it occurs. Bernstein and Navot (2020) have pointed out that these "forensic modes" also occur in general practice, but they are less prevalent and extreme. FST therapists need to become adept at recognizing and working with these extreme modes, especially when they occur in the "here and now" of the therapy relationship. Otherwise, these modes can easily "take over" the therapy sessions, leaving the patient in charge, and the therapist feeling helpless and ineffectual.

2. FST THERAPISTS NEED TO BECOME ADEPT AT WORKING WITH BOUNDARY VIOLATIONS.

Forensic modes often cross therapists' boundaries. These violations can be subtle, for example, when a patient asks minor, personal questions, or overt, as when a patient attempts to seduce or proposition his therapist, or suggests that he or she engage in illegal or rule-violating behavior. In order to recognize those boundary violations when they occur, and respond to them in the most efficient way, we have developed a new framework for conceptualizing boundary violations in terms of transgressions of four basic rights: safety, respect, privacy, and integrity (e.g., honesty). These rights apply to both the therapist and the patient (Bernstein & Navot, 2021). Therapists often find boundary violations disturbing and feel ill equipped to deal with them. Learning to deal with them in real time, when they occur, usually by empathically confronting or setting limits on the modes involved, empowers therapists. It also provides essential containment for forensic patients, who often lacked safe and consequential limits in their upbringings. By providing the combination of secure attachments and safe limits, the FST therapist provides a "corrective emotional experience" that leaves the patient feeling safer and more secure.

3. FST THERAPISTS NEED TO BE PREPARED THAT BUILDING AN ATTACHMENT RELATIONSHIP CAN BE A SLOW AND PAINSTAKING PROCESS.

Because of forensic patients' severe mistrust and extreme coping modes, building an attachment relationship often takes a year or more in FST. FST therapists need to learn to be patient. They face the challenge of providing for patients' unmet emotional needs ("limited reparenting") when patients are unwilling, or unable, to show any emotional vulnerability. The patient's history, as described in his or her dossier, often provides clues that allow therapists to glimpse this vulnerability. Stories of severe childhood abuse, neglect, abandonment, and domestic violence are the rule, rather than the exception, in forensic populations. The therapist forms a mental image of the child, and the unmet emotional needs, that lie behind the patient's protective shell. By adjusting his therapeutic style to provide for what the patient missed growing up – such as safety, reliability, honesty, warmth, genuineness, fair but firm limits – the therapist creates the conditions that over time, permit the patient to slowly bring down his wall.

4. FST NEEDS TO TAKE INTO ACCOUNT ISSUES OF MOTIVATION AND ENGAGEMENT IN THERAPY.

Therapy in forensic settings is usually, but not always, involuntary. Although patients may refuse to go to therapy, there are usually consequences for failing to do so, such as losing privileges or permission to go on leave. In some

cases, failing to attend therapy sessions may be a violation of a judge's order. Moreover, in closed forensic institutions, such as forensic hospitals and prisons, the entire environment may be experienced as coercive, with extreme restrictions on the patient's freedom. Finally, forensic patients may see little to gain from therapy, as they tend to externalize blame for problems, and fear that anything they reveal to therapists may be used against them.

FST therapists need to accept that difficulties with motivating and engaging patients are often front and center. However, rather than viewing patients as "resistant" or "untreatable," they understand motivational difficulties as deriving from patients' modes, which arise from the patient's mistrust and the circumstances of their treatment. We teach therapists to use an approach adapted from motivational interviewing (Miller & Rollnick, 2012), where motivation is considered to be dynamic and fluctuating, rather than fixed and permanent. We work with the modes that interfere with treatment, accepting them as the patient's attempts to cope with adverse circumstances, while exploring with the patient their advantages and disadvantages. In our experience, this motivational interviewing approach to modes slowly leads to greater motivation and engagement, enabling therapy to move forward.

5. FST THERAPISTS NEED TO BE WILLING TO WORK ON THEIR OWN MODES, AND GET THE SUPPORT TO DO SO.

Because forensic patients engage in behaviors that are far outside of normal human interactions, they can push therapists outside of their comfort zones. Not surprisingly, then, even experienced therapists can get their own modes triggered when working with forensic patients. FST therapists need to become adept at recognizing those moments when their own modes have become triggered, and finding ways of grounding themselves. We have developed a framework, the ORRI circle (Bernstein & Navot, 2020), for helping therapists in those moments when their modes are triggered. ORRI stands for Observe-Reflect-Recruit-Intervene. Therapists need to learn how to "slow things down" at those moments when their modes are triggered. This buys them important time to observe the patient's modes that are triggering them. Then, instead of just reacting to the patient's modes, they take a moment to reflect on what has gotten triggered by them. Which of their own modes have been triggered? What do they need to recruit their healthy adult mode to restore their equilibrium? These steps help to ground the therapist, who is now in a much better position to intervene from a position of health.

FST therapists need support to do this arduous work. They need regular supervision or peer-supervision, where they meet at least once per two weeks to discuss cases. Using supervision to discuss one's own modes is an essential aspect of these meetings. In some instances, therapists may take the opportunity to seek therapy for themselves. Becoming aware of,

and processing, one's own issues has value in its own right, and strengthens the therapist's capacity for managing the challenges posed by forensic patients.

6. FST FOCUSES ON RISK AND PROTECTIVE FACTORS, WHICH ARE UNDERSTOOD IN TERMS OF MODES.

FST is a humanistic enterprise, emphasizing the basic worth and dignity of all individuals. However, it is ultimately about reducing risk. The forensic field has made enormous progress in developing risk assessment instruments, based on empirically established risk and protective factors, to predict patients' degree of risk for (violent) recidivism. Nevertheless, progress in forensic treatment has lagged far behind. This has created a "Catch-22" situation, where we can predict which patients are likely to recidivate, but lack the means to help them. FST meets the need for an evidence-based treatment that has been shown to lower recidivism risk. In keeping with the risk-need-responsivity principles of forensic treatment, FST is a high-intensity treatment, often delivered twice per week, that matches these patients' high risk of recidivism.

In FST, we view dysfunctional modes as the internal, or psychological, risk factors for future crime and violence, and healthy modes as protective factors that mitigate recidivism. This view is supported by research that shows that modes play an important role in violence and other forms of externalizing behavior (Keulen de Vos et al., 2016; van Wijk-Herbrink et al., 2018). FST therapists work with their patients to examine the modes that are involved in their typical crime scenarios. They develop intervention strategies where the patient learns to recognize the modes that are the early warning signs of pending criminal behavior, and initiates alternative behaviors to break the chain before such behavior occurs. The FST therapist also calls the patient's attention to "offense-paralleling behaviors" that occur within the institution, or even in the therapy session itself. These behaviors are observed when the same modes that were responsible for crimes in the past occur in the "here and now." They provide an opportunity to work with patients' risk-related modes in real time. At the same time as they focus on risks, FST therapists help patients to find and utilize their strengths, which can serve as crucial protective factors. Over time, the balance between the modes that represent risks and protective factors shifts, and the patient's risk of recidivism diminishes.

7. FST IS A TEAM-SPORT. WHEN FST IS GIVEN IN INSTITUTIONAL SETTINGS, IT IS ALMOST ALWAYS DELIVERED IN THE CONTEXT OF A MULTIDISCIPLINARY TREATMENT TEAM.

The patient resides on a ward, and spends most of his time interacting with nursing staff. FST is often accompanied by other therapeutic modalities, such as group, creative, or occupational therapies. Experience shows that the same modes that create challenges for FST therapists can put pressure on the treatment team, especially nursing staff, who have the responsibility for managing difficult behavior on the ward. Under the stress caused by patients' extreme modes, dysfunctional patterns or "splits" often develop within the treatment team. For example, one of the most common is when some staff members strongly advocate for more limits or even harsh sanctions on the patients, whereas others argue just as vigorously that the patients just need more empathy and nurturance. Over time, these dysfunctional patterns can undermine teams' healthy functioning, and contribute to unsafe, overly harsh or permissive, or emotionally cold and distant climates on the ward. Sometimes, these patterns can include discrepancies between the modes that the patient displays inside and outside of their therapy sessions. For example, the patient may appear to engage in cooperative behavior with his therapist, while showing manipulative and antisocial behavior towards the ward staff.

SafePath, a team-based form of schema therapy, was developed by Dr. David Bernstein to support the healthy functioning of the team, and provide for more integrated multidisciplinary treatment. Research has shown that SafePath strengthens team functioning, improves ward climate, and reduces the need for severe, physical interventions with patients (van Wijk-Herbrink et al., 2021). FST is sometimes delivered in institutional environments that do not incorporate schema therapy principles. However, its effectiveness may be enhanced when the entire treatment team uses the concept and "language" of modes as an integrative framework.

CONCLUSIONS AND RECOMMENDATIONS

We've learned a lot about what makes FST different, and how to apply it effectively. The challenge now is dissemination. FST was developed primarily in the Netherlands, where it is officially recognized as an evidence-based treatment, and widely disseminated in forensic institutions. Since 2010, FST has been part of the curriculum of the Dutch Association for Cognitive-Behavior Therapy, where

it is given regularly as a course by Dr. Truus Kersten, Dr. David Bernstein, and other senior colleagues. There are only a few other countries (e.g., the United Kingdom, Germany, Australia) that are developing their own expertise in FST. The challenge moving forward will be how to create a framework to bring FST to other countries with high fidelity.

One recommendation is to make FST an official specialization within the ISST and create guidelines for its proper implementation, as well as recommendations for training and supervision in FST. This would encourage schema therapy institutes in more countries to add FST to their curricula, and create FST supervision and peer-supervision groups. Over time, these developments will enable FST to flourish, as schema therapists develop expertise in working with life at three standard deviations beyond the mean.

ABOUT LIMOR NAVOT

Ms. Limor Navot is a Psychologist who specializes in Schema Therapy for anger and aggression problems and personality disorders. She has extensive experience in forensic settings and served for several years in the Israeli Prison Service. She worked primarily with prisoners who committed murder and other violent offenses, fraud offenders, and served as the head psychologist for the women's prison. Today she works as a Head of Treatment in an in-patient clinic in the Netherlands for personality disorders and addictions. She is also the CTO and Training Director of the SafePath Institute.

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Dr. David Bernstein is a Clinical Psychologist and Professor at Maastricht University in the Netherlands, and the Founder and CEO of the SafePath Institute. He is a former President of the Association for Research on Personality Disorders and Vice-President of the ISST. He is the author of more than 120 publications on psychotherapy, personality disorders, forensic psychology, childhood trauma, and addictions. He is one of the pioneers in Schema Therapy, and is active as a Schema Therapy supervisor and trainer.

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LARS BANG MADSEN, PH.D.

THE PRISONER'S DILEMMA: LETTING GO OF THE OVERCOMPENSATING MODES

> "Is it better to serve in heaven or reign in hell?"
>
> **John Milton** Paradise Lost

Jon did not seem as fearsome as his reputation had made him out to be. Making his way up the prison spine (**term used to describe the main corridor in a prison*), he was shorter than me with a muscular build and shaved head, no visible tattoos, and he seemed remarkably well-groomed and clean in newly ironed prison overalls. The escorting staff also knew him well, and as they casually walked towards me were in animated conversation. Jon smiled and laughed, though I noticed his eyes constantly scanned the environment, acknowledging other prisoners with brief nods or raised eyebrows as they lined up for the various morning programs. While I could not be sure, it seemed that a hush descended upon the scene as congregating prisoners turned to the approaching threesome, whispering amongst each other, and appearing to acknowledge Jon deferentially.

Jon had been referred for one-to-one treatment after being removed from a group program for the intimation of other group participants. He had also recently been reintegrated after a lengthy period in maximum security. With a diagnosis of psychopathy, he was well known as a 'prison-heavy,' with undue influence and power in the prison environment. However, his exclusion from the group programs meant that individual treatment had to be attempted to give him the best opportunity to address his outstanding treatment needs. Within the literature, whether psychopathic personalities, such as Jon, can benefit from treatment is a contentious issue, and an oft levelled concern is that such clients become better 'predators' (e.g., Salekin, 2002). The truth is much less convenient, and in recent years there has been cautious optimism that positive change can occur for these challenging clients (e.g., Bernstein et al., 2021; Polaschek & Daly, 2013). Forensic schema therapy, a recent innovation, uses modes, particularly the so-called forensic modes identified by Bernstein and colleagues in the mid-2000s (e.g., Bernstein, Arntz, & de Vos, 2007), as a way of making sense of the challenging interpersonal dynamics that so often make the process of therapy a harrowing one. Indeed, it's dealing with these common problems that schema therapy comes to the fore because 'therapy-interfering' behaviours are understood as evidence of the client's maladaptive coping modes. Modes that emerged in childhood to protect them, though invariably, have also become integral in their offending histories as adults.

'I have been expecting you,' Jon confidently asserted with a smile, an outstretched hand, and

an intense stare. Softly spoken, articulate, polite, and thoroughly in control, with a disconcerting firm handshake, our five-year schema therapy journey began.

Forensic contexts differ from the more traditional clinical contexts in several important ways. Clients are typically mandated in one way or another, and while mental health concerns are relevant, such a focus is subordinate to the so-called' reoffending' risk. These clients typically will want treatment or, more precisely, *proof* of having completed *offence-specific* treatment to show decision-makers that they are fit to return to the community or gain some additional privilege. Given this context, it is perhaps no surprise that much of the focus of our initial year felt more like a long game of chess, with every session feeling like a negotiation for determining what could be exchanged and at what cost. Jon wanted reassurance that 'it' would all be worth his while and that he would be better off quantifiably at the end of therapy (i.e., physical privileges, community access). Of course, as a therapist in this context, such reassurances are impossible, and while validating his concerns, I constantly needed to 'reality test' his reasoning. Jon had spent most of his adult life in custody; his last time in the community had only lasted three weeks. Most of his jail time had been spent in the highest secure contexts, sometimes in maximum security or more accurately described as solitary confinement. We would later label this 'side' of him as '*the Barrister* ', an *over-controller manipulative* mode that sought to gain the upper hand in interactions with management (and counsellors) and obfuscate with clever debate, *'sleights of hand',* and occasional subtle and then not-so-subtle displays of intimidation.

Jon grasped the schema model quickly, and his eventual mode map contained the expected vulnerable and avoidant modes (i.e., the abused child, detached self-soother, avoidant/angry protector) in addition to all the overcompensating modes. He found the use of modes particularly helpful as it allowed the exploration of the 'sides' of him that felt angry, vengeful, or simply numb without the sense of being wholly condemned, the typical felt experience in many correctional programs. Jon's childhood was like many forensic clients, devoid of love, safety, protection, spontaneity, and fun. His earliest memories were of hiding with his mother in bushes as his enraged and drunken father roamed the house looking for them with a machete. Shortly after, his mother abandoned him to the care of his father, who died suddenly. After this, he was shuffled between relatives he barely knew and who had little interest in caring for him. There was sexual and physical abuse, drug addiction, alcohol misuse and juvenile delinquency. He spent his 11th birthday in a boys' home. Here, being small in stature and young, he was often the target of bullies and abusers, and in the 'dog-eat-dog' culture of institutional environments, he learnt quickly that the only way to be safe was to be feared. By age 14, he had been raped 'countless times', worked as a prostitute while homeless, and abducted and used in a child pornography film on one occasion. *'I realised that people are disposable,'* he reflected and recalled consciously honing his skills at identifying vulnerabilities in others he could exploit and threats to avoid or eliminate. On the streets, he mainly got by using deceit (conning manipulator) and intimidation (bully attack) to get the things he wanted, but it was wholly different in custody. It was perhaps because of the brutality of his early introduction to the institutional environment that he promised himself that as a young person returning to this environment, he would tolerate no vulnerability, and just like that the Faustian bargain was struck.

> *The sexual assaults in the boys' homes taught me about fear and how to control others; to be scotched* was the worst thing that could happen to you, and I used that fear when I returned to prison'*

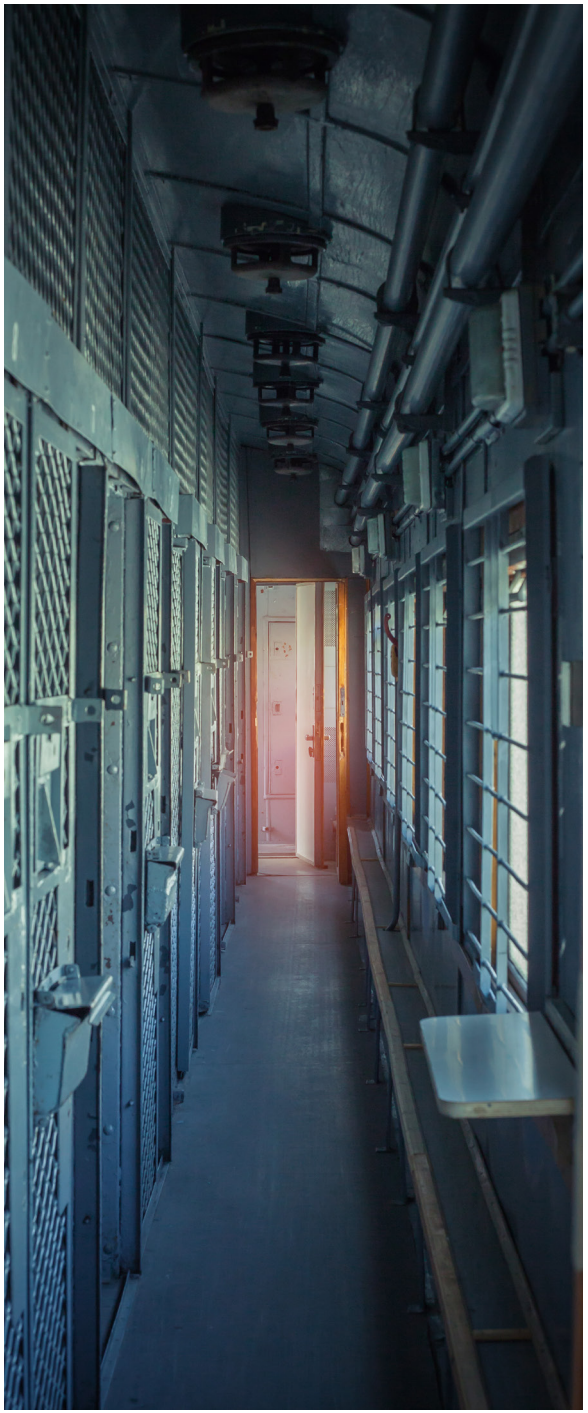
(*To be 'scotched' is prison slang for being raped in custody)

From his return to custody, Jon described a chronic pattern of sexual violence focused on controlling the prison environment, eliminating rivals, and gratifying himself. In schema therapy, he eventually broke down these offences detailing the key modes and mode sequences that played a part. For instance, in the prison environment, he constantly scanned for threats (paranoid over controller); anyone identified as such needed to be eliminated (predator), and his use of sexual violence on these occasions was explicitly motivated to cause maximal injury and humiliation to destroy the victim psychologically. On other occasions, he used sexual violence to relieve boredom (detached self-stimulator), intimidate the prison unit and assert his supposed authority (bully and attack) or revel in the sense of power and control (self-aggrandizer). Early in the therapy, there was only a cursory acknowledgement of his vulnerable child (*'yeah, it's there, but I am over it'*). His core activating schemas seemed primarily to be 'mistrust and abuse' (i.e., people are going to hurt me) or 'entitlement' ('I deserve this'), and a notable recurring feature of the retelling of his callousness was simultaneously a sense of self-aggrandisement and menace.

For these reasons, limited reparenting was complicated. Jon's essential unmet emotional needs were safety, trust, fairness, and justice. Early in the therapy, there was very little access to his vulnerable sides, and the times we had attempted imagery, it had not gone well. Jon struggled to close his eyes and feel safe in the room. When he could do this, he did not sit with vulnerability for long and flipped into a menacing and scary overcompensating mode or wholly detached.

In these harrowing moments, I learnt that it was essential to remain present physically and psychologically speaking (I was scared and wanted to run), and, as best as I could, be empathic but also authentic and genuine about the effect of his behaviour on me. I noticed that by repeatedly being able to link his current coping modes to his appalling child abuse history and conceptualising his reactions as understandable given this context, he started to soften. He had always been labelled a 'monster', and while a part of him revelled in the notoriety, the label was heavy to bear and came at a significant cost. Always being 'on' (i.e., hypervigilant) and ready to respond to challenges was exhausting, and the physical toll of fighting accumulated. In our fourth year, Jon spoke about vulnerability and love. He had an intellectual sense of these things and an emerging awareness that being safe, understood, and genuinely cared for by another would be good. He occasionally wept when talking about these things and could intellectually recognise the overcompensating modes for what they were. The imagery was still challenging for him, and he preferred chair work for debating with the avoidant and overcompensating sides. His vulnerable child could now be in the room, but accessing it remained problematic and complicated.

Given his institutional history, it was perhaps inevitable. One day when I attended the prison for our regular session, I was informed that he had been returned to maximum security. Seeing Jon behind the bulletproof glass in handcuffs was difficult, and in our initial session here, I could see that the Barrister was in full flight. "There's a misunderstanding… how does one actually define consent?… It's not what happened, Lars, it's what you can prove!. In subsequent sessions, Jon seemed more authentic though resigned and reflected, *'Maybe this is all I am. When I walk out of here eventually and into a unit, I own it and everyone in it; why would I give that up?'* In prison, memories are long, and grudges are held, the higher you are in the dominance hierarchy, the greater the fall. Having



some understanding of Jon's reign of terror, I understood the implications of letting go of the overcompensating modes and the dilemma he confronted.

Because of the additional charges, the institution eventually stopped our sessions. Over time, Jon had become increasingly despondent about his prospects for the future; however, he remained engaged in our sessions but often wanted to only talk about how he had been feeling and the new hobbies he had developed. In our final session, he looked like an accountant shuffling into the non-contacts booth with a trim greying bread, round glasses, and a middle-aged paunch. He told me excitedly about having passed the initial semester of a university mathematics degree, '*Hah, not bad for someone that only completed schooling to grade seven,*' he gloated but then became teary, said thank you and immediately called the officers to take him back to his cell.

Months later, a retired priest supporting Jon contacted me, asking whether I would be on his parole application as his therapist. He spoke confidently about Jon's innocence and the impending court matters; I nodded politely thinking about Jon's *Barrister* mode and how convincing it could be. I, of course, agreed to see Jon should he gain release, but I knew that this would not happen any time soon.

Jon would undoubtedly represent one of the most extreme presentations in a forensic context. Schema therapy was attempted with him over five years under challenging circumstances, and while this was ended prematurely, there was evidence that this had benefited him. Towards the end of our time together, he was able to be vulnerable, the size of the overcompensating modes had reduced, and he verbalised acknowledgement and desire for connection and love. I believe that some of the key ingredients to this progress was the *'in the moment'* limited reparenting moments of being authentic, compassionate, and warm, however, also setting limits to the overcompensating modes and holding these aspects of him accountable. And, of course, there was time. The five years of working together using the schema model provided the opportunity to embody a predictable, consistent, and genuine attachment.

ABOUT LARS BANG MADSEN

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FORENSICS, SPEECHLESSNESS AND THE HEALING POWER OF "SCHEMATHERAPY-SPEAK"

THE CASE OF A YOUNG MAN SHOWS HOW, THROUGH THE LANGUAGE OF SCHEMA THERAPY, GENUINE REFERENCE TAKES THE PLACE OF DEADLY SELF-REFERENCE

The first major obstacle of forensic psychotherapies is often language. Either talking about displayed behavior and its primarily emotional "drivers"is rejected as "psycho-talk" or even ridiculed. At times "psycho-talk" is over-emphasised - not so much to understand or change something„ but to build up a pseudo-hysterical context in which one "finally opens up." The reality, however, seeks above all to avoid any confrontation with maladaptive patterns or schemas. This process prevents confrontation with guilt, greed, sadism and other problematic concerns that are very often the key problems of prison inmates.

In fact, practice has shown that this "language problem" can be overcome with the help of "schematherapy-speak". This is because it works like a language in its own right, limited to a concise set of vocabulary and an easy-to-learn grammar. Modes provide a language in which forensic patients can understand their actions (even the cruelest of offenses) in a manner that is different from the moral pressure of phenomenally oriented therapy languages, which often start with seeing the patient as a moral actor. A tendency towards defense on the part of the patient then becomes one of a "scientist of oneself" who is receptive to an exploration of their modal chains and schema dynamics, or their triggers.

THE FOLLOWING CASE EXAMPLE ILLUSTRATES THE BENEFITS OF SCHEMATHERAPY-SPEAK WITH A FORENSIC PATIENT.

A young man in Austria faces a life sentence in prison for the murder of his pregnant wife and his son. As a child, this man grew up in a good social environment and received a good education. Despite this, the man struggled to be seen in his family and to relate to others generally, which led to social isolation. After graduating from school, this man began a relationship with a woman that in many ways mimicked the dynamics of his youth. He became the dependent partner who was overwhelmed by the demands of family relationships and under-functioned as a spouse and parent. Frequent conflict triggered the man's underlying schemas and activated an "angry attacker" mode that tragically led him to murder his pregnant wife – ostensibly to free himself from the pressure of underlying schemas. This unfortunate tragedy worsened when the man fled with his son. A manhunt ensued, and the man (in what was seen as a "panic-motivated attack") suffocated his distressed son in the hopes of avoiding capture.

Not surprisingly, when we began our work with this young man, he was more

than ever where he had always been. Namely isolated, unable to relate to himself or others, and (in schematherapy-speak) engulfed by his "detached protector" mode.

Our first steps involved building trust and developing a shared language to explore this man's self-concept and actions separate from the conventions of morality, guilt and criminality. We achieved this through the language of schema therapy.

For this man, the process of learning this new language was almost mathematical and abstract – including the new "grammar" of modes. Experiences and themes such as "not seen well," "dependence," "excessive demands," and "angry attacker" were increasingly more understood using the language of schema therapy. For this young man, organizing his schema-mode "grammar" into coherent stories or "symbols" aided him in understanding his tragic life patterns involving emotional deprivation, social isolation and other schema-modes.

This branching off into semiotics may seem strange, but it opens up something: symbols like codes are changeable and change concretely when new insight leads to new meaning. . Even understood only as a metaphor, this allows the option of a changeability that has a technical or semiotic character and therefore appears neither inscrutable nor unfeasible - which is often the case in common "psycho"-psychotherapies.

The second step may therefore seem obvious: to change the symbol that the young man has formed and embodies. In other words, to use insight and meaning-making to enable a "re-interpretation" of one's life pattern. Which is what many psychotherapies produce in practice when they focus on and emphasize "relationship work". In the end, this is another formulation for the semiotic event that consists in the re-contextualisation and re-relation of a symbol, which changes its content.

The difficulty of this approach is easily recognizable: the symbol remains simply a symbol, or to put it metaphorically again: it remains something like a pictorial "logo", even if it now indicates something else. Sometimes, however, for various therapeutic reasons, more is needed - which can be compared to turning a "logo" into at least a meaningful "statement" or a "philosophy in a nutshell".

One of the great qualities of schema therapy is that it can do exactly that; namely, using schematherapy-speak to help patients conceptualize complicated

life patterns with coherent schemas and modes. In this understanding, a new relatedness to oneself and to the world is also established, which can also be called *"interpretant relatedness." Someone who is in his schema (in this "code structure"), builds up a "schema relation" to himself and to the world, (i.e., a relation that primarily emphasizes the identity of a new event with an old experience). Thus, from the point of view of the schema carrier (i.e., a "self-referential relation"), the interpretant relation actually produces relations.*

Just as in a work of art, figure A is related to figure B through the gaze of the interpreter or interpretant, and this relationship is again related to a certain picture surface or color combination, the person who learns not only to recognize and name her schem, but also to grasp them in their relationality. In other words become an interpretant of her emotion-code-based "experience-picture", which is also called "psyche". Their reference is thus no longer that of identity matching, as it belongs to the schema code or sign, but that of the "law", because abstract principles of relational connections make up the being-referred.

The second step, therefore, consisted above all in making not only the modes (categorically) conceivable and "re-experienceable," but also showing their continued interplay. This latter element helps strongly establish *explicit relational thinking* and thus an *interpretant position*. This worked well and gave the young man an impression of "being free."

This shift in perspective also helped this man distinguish between his "old life" and his new one – a life in which he understood how certain situations activated schemas-modes and how he now had more agency over them. At this point, it was now possible to discuss the deep guilt and grief associated with the serious offenses. In fact, in one therapy session, a sealed envelope containing the photo of the son who had been killed was opened.

The third step not only helped this man process the consequences of the offense, it also helped him see that the interpretant position can be a "general way of life." This position is not just a means to create "optimal" protection against "triggering" schemas, but also a form of "self-reference" to oneself and the world.

Expanding on the idea of "self-reference," consider that it is not only the interpreter of classical artwork, the social sculpture or the installation who experiences the "tranquility and mobility of beauty." Because beauty is probably less an emotion than an *immanent* quality of (ultimately *semiotic*) *relations* and r*elational references*, aesthetics and aesthetic experience. These also belong to a developed "interpretant-reference." Certainly a *new quality of experience with which* one is connected qualitatively (and *more than equal to emotions* and emotional experience) with "things" and "doing," more than compensates for the "better or worse" powerful self-reference of the schemas that present as "nature" and a fundamental "intuition form" (as Kant describes).

Accordingly, special emphasis was placed on this aesthetic dimension of the interpretant's reference - which made the young man rediscover craft, sport and studies. Sport, for example, now provides him with an outlet to "sink" relational complexities into body flow, which the interpretant has grasped. Which is why, for example, the game of darts is experienced primarily aesthetically and as *flow* - which is likely the means through which this man mastered the activity.

In the fourth step, which we have just begun, the focus falls on the rhythms of "interpretant life," which is an essential part of this new developed life. This view is consistent with French philosopher of science Gaston Bachelard's "rhythmoanalysis," which he developed a century ago with the view of transforming characterological rigidity. As this man has only begun this step, we will have more to present on his progress in the future.

Through the case presented above we demonstrate how a modified schema therapy using a grammatological-semiotic (i.e., structuralist) approach can be effective with forensic populations. We propose that "structural schema therapy" receive more consideration for this population, which to date receives only limited options for treatment.

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GROUP THERAPY FOR DUAL PATHOLOGY: ANTISOCIAL PERSONALITY DISORDERS WITH SUBSTANCE DEPENDENCE

We refer to dual pathology when the patient simultaneously has a mental health disorder and an addictive disorder, the latter being characterized by the repeated use of one or more psychoactive substances that produce immediate pleasure and in turn reduce the discomfort caused by the symptoms of the mental health disorder. The substance use is seen as a way of "self-medicating, from the self-soothing mode, although the long term consequences are harmful, or cause a significant deterioration in social development. (Ruíz, J., Pérez, P., 2014).

Schema therapy is an ideal approach to intervene with dual pathology, since we can intervene simultaneously and comprehensively with both pathologies, unlike previous methods that focus solely on interventions directed toward the substance use. A danger of that model is that often the only indicator of treatment effectiveness is abstinence; abstinence, or abstinence alone cannot guarantee the general improvement of the patient.

It is common for patients to continue consuming in the early stages of treatment because their schemes are persistently activated; this does not mean that therapy is "not working." We must bear in mind that the therapeutic objectives are not only the reduction of symptoms of the addictive disorder, but also the management of ineffective or destructive coping modes and healing early maladaptive schemas .

Samuel Ball was the first schema therapist who worked with dual pathology in 1988, calling it "Dual-focus schema therapy" His approach consisted of a 24-week manual addressing different topics related to drug use and eating disorders, gaining and understanding a patient's personality from the evaluation and conceptualization of early maladaptive schemas and dysfunctional coping

strategies. He revisited the classic model of relapse prevention by Marlatt and Gordon (1985), coping skills training (self-monitoring, conflict resolution, and social skills) and schema therapy strategies. (Ball, Cobb-Richardson, Connolly, O'Neil, 2005; Ball 2007).

THE THERAPEUTIC RELATIONSHIP

Patients with personality disorders, and even more so with dual pathology, have significant difficulties in their interpersonal relationships Because their symptoms are egosyntonic, they are not aware that their disorders negatively affect other people, or that the behaviors associated with their disorder (their drug use) frequently activates the early maladaptive schemas of the people around them. Their substance use may lead to their failure to fulfill their duties, and may lead to the reduction or abandonment of their social, professional or leisure activities; leading them to drift away from and lose the support of their families, friends, and other social groups.

In view of this, the initial intervention should be directed to a great extent at improving the patient's social ties and relationships, because these problems can also be reflected in the context of the therapeutic relationship. We begin treatment by engaging the patient to remain in treatment for the time necessary for us to reach the therapeutic objectives and significantly reduce their symptoms. It has been shown that the greater the commitment and duration in therapy, the better results will be obtained.

Patients tend to seek treatment when their symptoms are acute; when the suffering decreases they are likely to leave the treatment. For this reason we have to prioritize the therapeutic alliance to prevent patients from prematurely dropping out of the psychotherapeutic process.

It has been found that people with dual pathology drop out of treatment within the first three months of therapy due to factors including patients being in treatment involuntarily, having negative assumptions about treatment, and having unpleasant experiences in prior treatments. These factors are in addition to the normal anxiety that change generates - including suggestions of giving up self-soothing behaviors that they have relied upon, and so activating their vulnerability in therapy.

The schema therapist must have an open and flexible perception regarding drug use, avoid negative assumptions about patients, since if we have a critical or stigmatizing attitude towards the patient, we can activate schemas, such as emotional deprivation, or mistrust/abuse. This can trigger maladaptive coping styles, including surrender, avoidance or overcompensation with behaviors such as lying, cheating, or defensiveness, and feelings of mistrust of the therapist. All of this can undermine the therapeutic relationship, undermining the therapy

IMAGERY RESCRIPTING FOR ADDICTIVE BEHAVIOR

This adaptation of the classic imagery rescripting will help us, together with the patient, to remember childhood and/or adolescence experiences that allow us to identify the origin of the early maladaptive schemas related to consumption and the first experiences of the self-soothing coping mode. It will include the following steps:

- Introduction and psychoeducation work with diagnostic imagery .
- Provide security.
- In imagery relive the experience of craving or anxiety for consumption in the present. The objective is to evoke the experience to make an affective bridge with the origin of the addictive behavior.
- Intensify emotions and connection with bodily sensations (directed emotional activation). We work on connecting the emotions associated with craving or anxiety for consumption in order to make the affective bridge.
- Once the patient feels the craving, and is very activated, we ask them to concentrate as much as possible on their sensations and to let go of the image. We then ask them to travel to the past with those same emotions until they find an image that matches the feeling of craving.
- Exploration of adverse or traumatic childhood experience: Together with the patient, from his child's perspective, we guide him to describe the entire image as specifically as possible, explaining all the details, as if we could talk to the boy or girl that is being described.
- Recruit the "helpers": We are going to recruit or bring details to the image, as if we could talk to the boy or girl being described.
- Fight against the antagonist: Now, together with the "helpers" we will help the patient to combat or establish limits to any figure or person who was part of the origin.
- Comfort the vulnerable child: We reparent the vulnerable boy or girl by meeting the basic emotional needs that were not met in the image.
- End the rescripting with an enjoyable activity: Before finishing the imagery, it is important to engage the "child" in a pleasant activity, to emotionally regulate the patient and not leave the image with the patient craving after the session. If a patient leaves the imagery with their cravings activated, they could be at risk of using the substance to which they are addicted.
- Return the patient to their safe place.
- Review and discussion of the imagery rescripting exercise.

TRANSFORMATIONAL CHAIRWORK FOR DUAL PATHOLOGY

Scott Kellogg designed his work with transformational chairs in 2014, designing and refining different strategies with chairs to work with substance abuse, emphasizing that the patient is the one who needs to decide for himself to discontinue substance use, because most patients ambivalent in their decision-making regarding maintaining use or quitting the substance (Kellogg & Tatarsky, 2012).

MOTIVATIONAL DIALOGUES

These are based on the understanding that all patients partly want to continue their drug use and partly want a real change, either to stop using the drug or to moderate their use. This ambivalence causes a state of inner conflict for the patient, intensifying critical modes and avoidance modes such as self-soothing, thus increasing the patient's likelihood of consumption.

Initially, to work on motivational dialogues and ambivalence, it is necessary to carry out a decisional balance (Marlatt & Gordon, 1985) to identify the reasons or positive aspects of the use of substances and the consequences or aspects perceived as negative of the substance, for which it is necessary need to change.

This entails creating a quadrant in which to view the information representing each voice in the dialogues and quantify them subjectively from 1 to 10 based upon the power of each.. (Kellogg & Tatarsky, 2012).

Once we have made the decisional balance, we can invite the patient to carry out the dialogue in two chairs, where the first character will represent the positive aspects of consumption and the negative aspects of change (naming it, for example " Mr. Smoker") and in the other will be our second character, which includes the negative aspects of consumption and the positive aspects of change (naming it, for example, "Mr. Motivated"). So using the decisional balance as our reference, and the patient providing the arguments, the therapist can help each character verbalize those advantages and disadvantages to help them move from the phase of motivation that our patient is in.

However, there are some additional issues to consider.

RELATIONAL DIALOGUES

Denning (2000) mentioned that people get involved in relationships with drugs, which parallel the relationships we establish with other people. So it is very effective to write goodbye letters to drugs from many treatment perspectives.

Kellogg adapted these arguments in his work with chairs. We can simply place any drug in a chair in front of the patient to begin the dialogues. We include in the conversation the nature or cycle of the relationship and identify: how and where they met; what circumstances keep them together; and, how their current relationship is working. Subsequently the patient can change chairs and speak from the perspective of the drug - and, if necessary, the perspectives of multiple drugs to assess whether the relationship may be different with each, or whether the reasons for maintenance are the same.

ASSERTIVE DIALOGUES

It is very common that when patients want to quit using drugs, part of the challenge involves fighting against their social groups who are likely also drug users. These social groups may pressure the patient by offering and facilitating drug use. The patient may also give in to social pressure to avoid being perceived as a hypocrite for having used drugs in the past. For these patients negotiating these relationships and interactions is particularly difficult, since they did not learn to establish limits and communicate directly, and they likely subjugate their needs and rights to avoid rejection by their peers, since "following the pack" was a survival strategy.

In this strategy, mode work with chairs enables the patient to play the role of the individual who offers drugs to the patient, the consuming friend or the people trying to convince the patient of the benefits of continuing to consume, while the therapist in the role of the patient can model ways to reject the social pressure, using different strategies of assertiveness and limit setting. In this way, roles can be exchanged until the patient feels the self-efficacy necessary to not acquiesce when offered the substance.

ROLE AND IDENTITY DIALOGUES

It has been found that most people who quit drugs recover on their own, without any treatment, and it is assumed from this theory that they recovered from addiction, because they found a more meaningful and reinforcing identity without the addictive behaviors.

To this end, Kellog uses identity dialogues by placing the patient in two roles: the "Addicted Self" chair (with phrases like: "I need the drug, it's part of me") and "Father Self" chair (with phrases like "I don't want my children to think that their father is a druggie").

These dialogues are carried out experientially, that is, connecting to the emotions experienced, so that the patient can prioritize and rank the other roles in his life as more important to his "Addicted Self". We can even place other roles into chairs, allowing the patient to dialogue with his "Addict Self", with his "Future Self", his "Professional Self", his "Son Self" or his "Brother Self". This helps the patient to connect with the priorities of his life, his basic emotional needs and his real emotions.

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