

The Forensic Schema Sessions: 2-Day Workshop

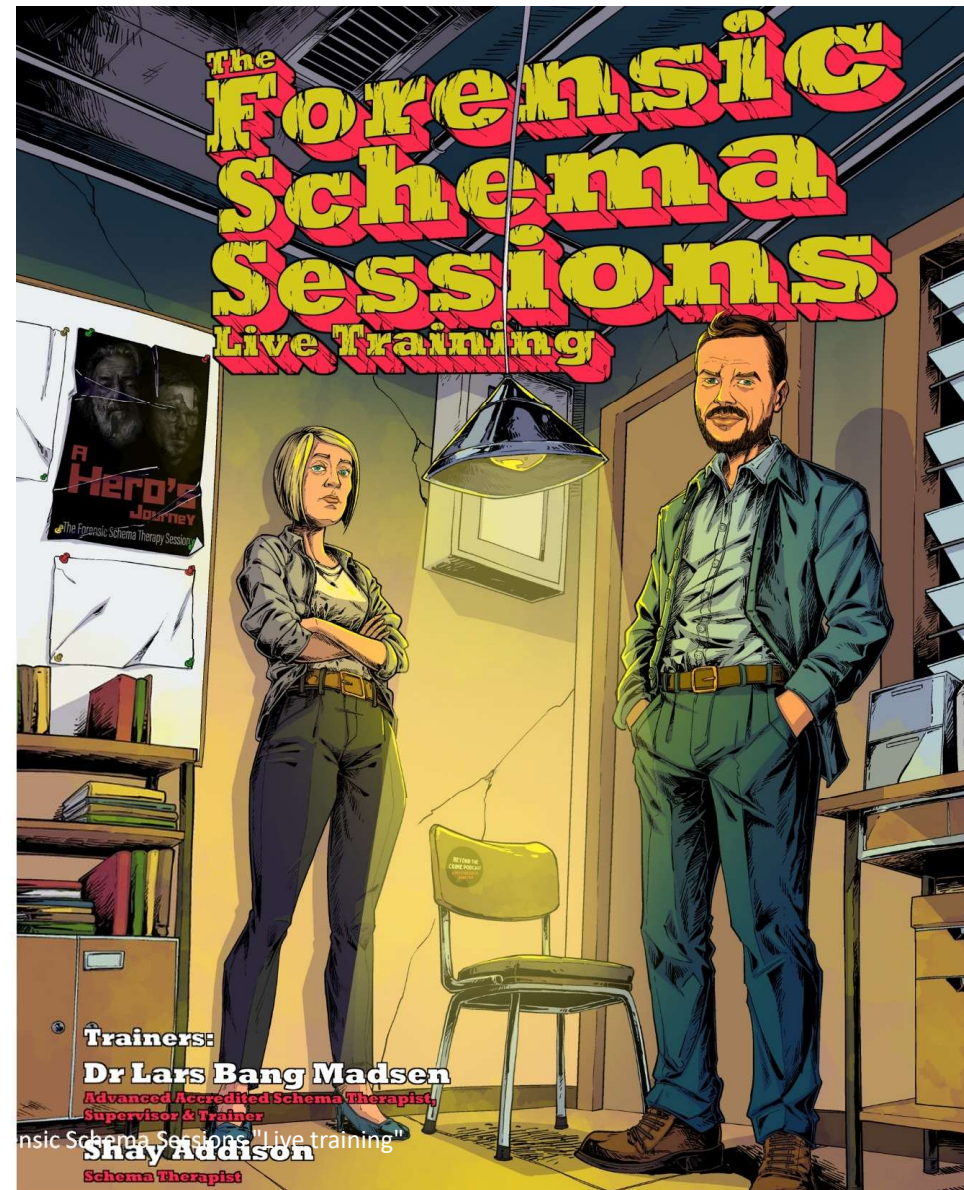
Queenstown, New Zealand 26/27 June 2025

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Forensic + Clinical Psychology Centre

Treatment | Assessment | Consultancy



Goals of the Workshop

You will learn:

- To recognize and distinguish the various schema modes, with a focus on forensic modes
- To develop a forensic client's individualized schema mode map, and offence pathway using the modes
- To navigate, bypass, and set limits to the schema modes that block progress for clients
- To craft a '*healthy adult therapist*' mode that is fit-for-purpose in the forensic context

Agenda Day 1

- Why Forensic Schema Therapy?
 - Contexts, goals & expectations, and the clients
- Modes & Key Therapist Challenges
 - Identifying the 'correct' modes in forensic clients
 - Mode mapping in the 'here & now' and historical offences
 - Conceptualising forensic clients in terms of modes
- Getting Started with Forensic Clients
 - Limited reparenting
 - Pitfalls and key tips

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Agenda Day 2

- Key Problems: Wrong modes & getting triggered
- Dealing with the overcompensating & avoidant modes
 - Limit setting
 - Chair work
- Imagery rescripting
- Developing a 'fit-for-purpose' healthy adult therapist mode

Warm up : Take a moment to reflect

- Where are you in your schema therapy journey?
- Key **differences** when working with forensic clients compared to clinical clients
- Key challenges **using schema therapy** with forensic clients



Clinical Versus Forensic

Important & Key Differences

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	Clinical	Forensic
Motivation	Voluntary Intrinsic Greater self control Less severe attachment problems	Typically mandated Extrinsic (generally) Sense of imposition Typically severe attachment problems
Goals	Collaborative / negotiated Improving mental health and functioning Reducing impact of negative schemas Developing skills to get needs met in healthy ways	Imposed by institution / authorities Reducing risk of re-offending Mental health concerns less of a priority if not related to risk
Contextual	Clinical / hospital Supportive, understanding	'Coercive' institutions (forensic hospitals, prison, parole/probation) Restrictions on behaviour Risk monitored Consequences applied for non-cooperation and perceived lack of progress Ethical dilemmas
Culture	Generally positive view of client	Negative (likely) view of client (and therapist)

Prison Culture: Relevance of dominance hierarchy

The social ranking of prisoners based on status, control, and influence over others:

- **Physicality:** Muscular inmates are often equated with strength and gain more respect.
- **Violence Potential:** Willingness and ability to use violence boost
- **Affiliations:** Association with gangs
- **Access to Contraband:** Control over contraband
- **Previous Crimes:** The nature and notoriety of past crimes.
- **Age:** Older inmates may be considered wise and influential.



Key challenge: Institutional violence

1. Prisoner-to-Prisoner and Prisoner-to-Staff Violence

- *Assault Rate:*

"In 2020, the assault rate among prisoners was **24.8 per 100 prisoners.**" (Australian Institute of Criminology, 2020)

- *Staff Assault Increase:*

"A **46% increase** in assaults on correctional officers reported over five years." (Inspector of Custodial Services NSW, 2021)

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Key challenge: Self harm

2. Self-harm and Mental Health in Custody

- *Self-Harm History at Entry:*

"21% of prisoners reported a history of self-harm upon entry, with females at 42% and males at 17%." (Australian Institute of Health and Welfare, 2022)

- *Self-Inflicted Death Rate:*

"The average self-inflicted death rate among sentenced prisoners was 0.35 per 1,000 between 1999 and 2013." (Australian Institute of Criminology)





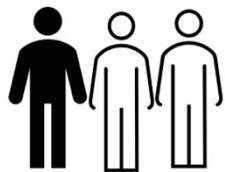
Why Forensic Schema Therapy?

- Much of the **criminogenic interventions manualized approaches focusing on specific types** of perpetrators, family violence, sex offending, violence, drug abuse etc. (e.g. Gannon, et. al., 2019)
- **Inconsistent** findings across contexts, offence types and patient characteristics (e.g. Sousa, et. al., 2022)
- Disparity in outcomes due additional factors that **cannot be accounted for or considered in treatment such as PDs**

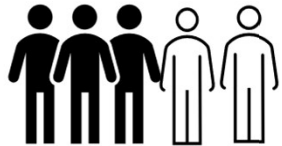
Why Forensic Schema Therapy?

- Developed by Bernstein and colleagues in mid 2000's (e.g. Bernstein, Arntz, & Vos, 2007)
- ST using primarily schemas (not modes) had been successfully applied to treatment of borderline, narcissistic & cluster C PDs (Farrell, Shaw, & Webber, 2009; Bamelis, Evers, Spinhoven, & Arntz, 2014; Nadort, et al., 2009)
- Key innovation of the introduction/ 'discovery' of the forensic modes:
 - **Bully & Attack**
 - **Self Aggrandizer**
 - **Predator**
 - **Conning Manipulator**

Descriptive Characteristics of Post Custody High Risk Offenders (n=54)



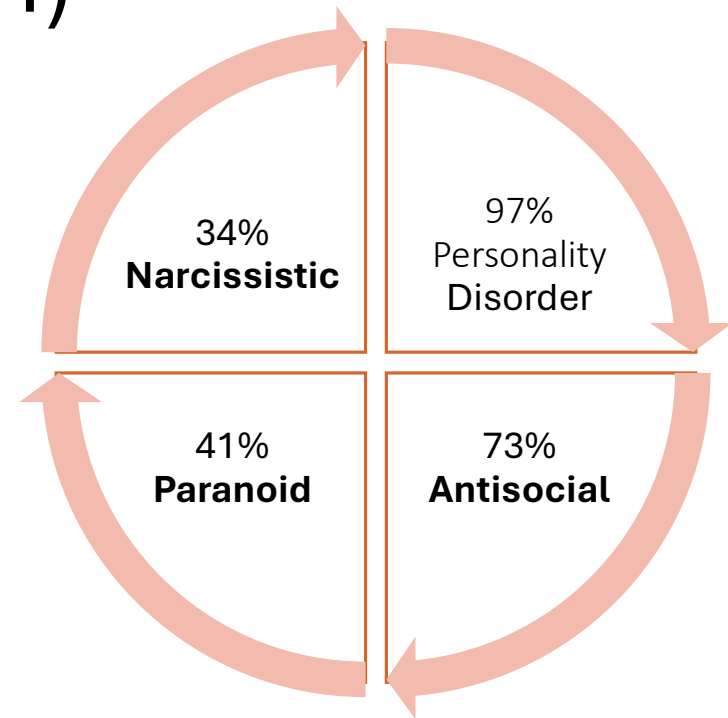
@1 in 3
Psychopathic
(28%)



@ 3 in 5 **Sexually**
deviant (67%)

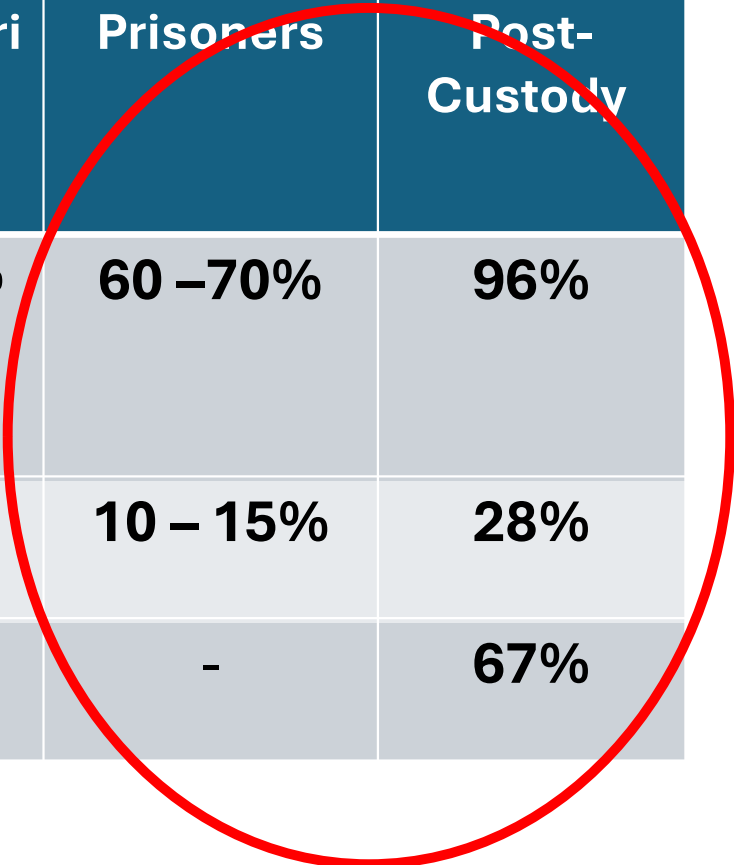


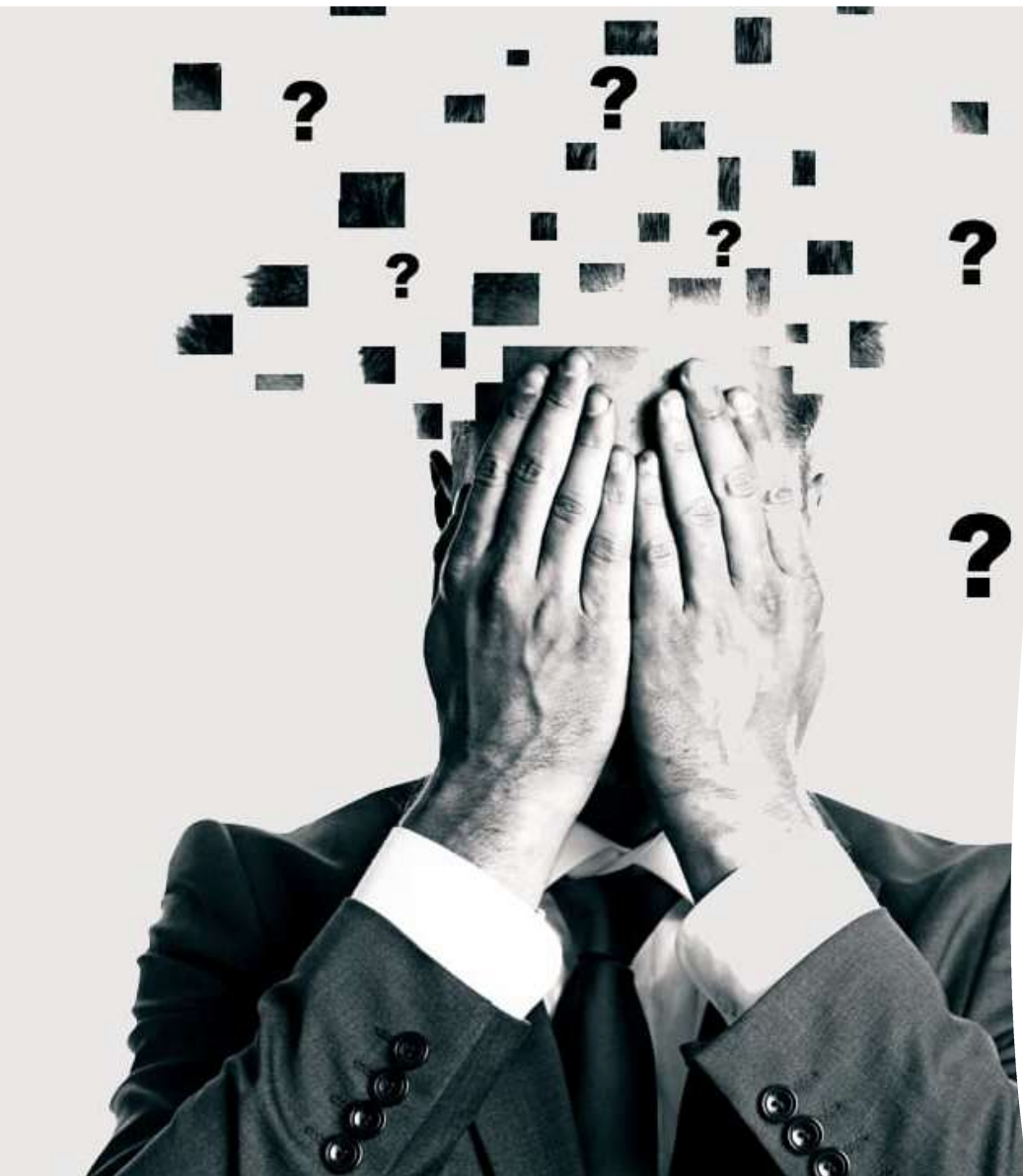
@ 9 out of 10
Personality
Disorder (96%)



Compared to everyone else (e.g., Akkers, et. al., 2011; NOMS, 2015; Santilla, et. al., 2010)

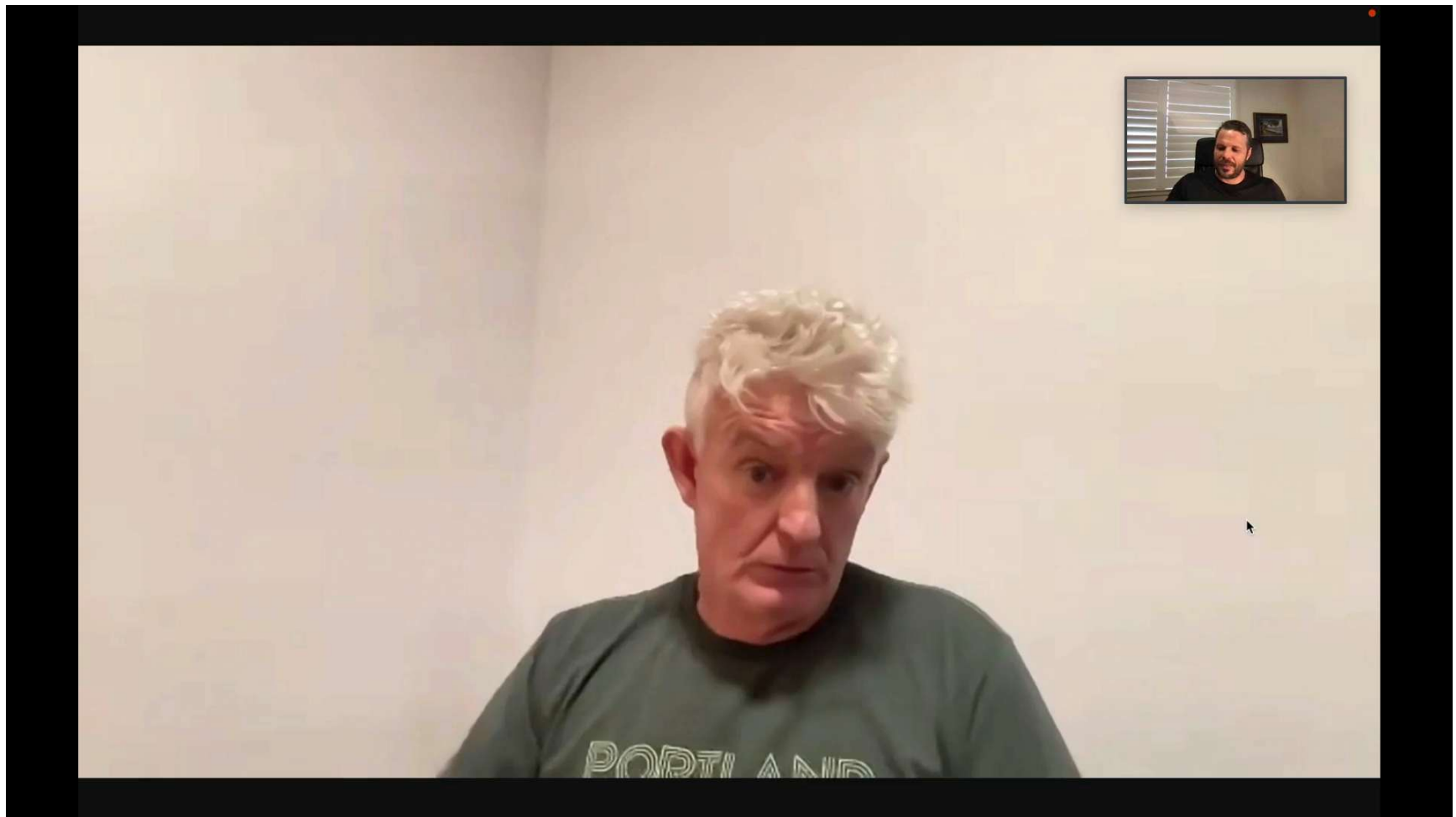
	General Pop	Clinical Pop	Psychiatric Hos Pop.	Prisoners	Post-Custody
<i>Personality Disorder</i>	5 – 10%	20 – 30%	30 – 40%	60 – 70%	96%
<i>Psychopathy</i>	0.75 - 1%	-	-	10 – 15%	28%
<i>Sexual Deviancy</i>	3 – 9% (males)	-	-	-	67%





Forensic Contexts & Severe PD: the issue of responsivity

- One of the biggest challenges with severe PD is the issue of **responsivity**
- Forensic clients are different to clinical clients:
 - **More Mistrust** you and the process
 - **More Exploitative and deceptive** about intentions & goals
 - **More Interpersonal hostility & aggression** in session
 - **More Impulsivity**
 - **More Resistance** to therapeutic goals / objectives
 - **More Attempt to control** the process
 - **More Detachment**



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The Treatment Failures...

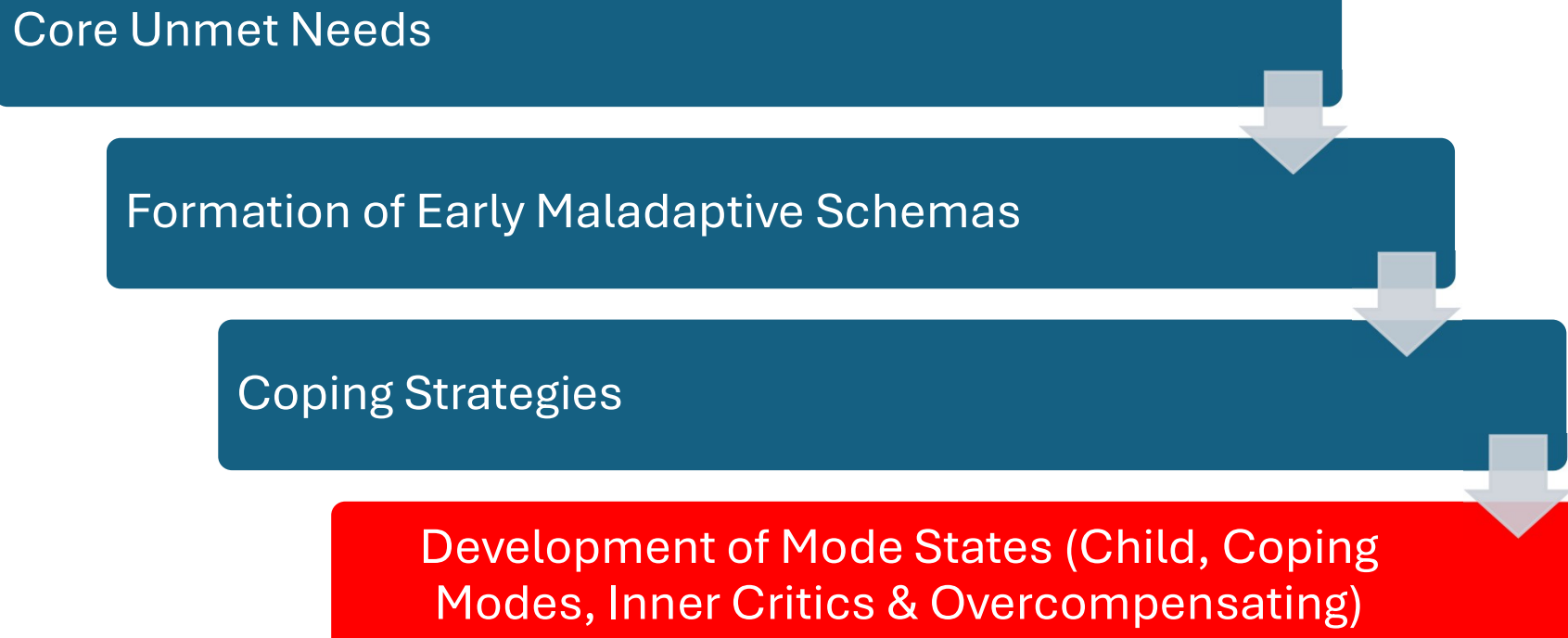
- Many offenders struggle to complete the group programs or indeed engage in any offence specific treatment whilst in custody
- They either refuse, are removed from the group program, drop-out, or simply evaluated to have not benefited

"Life looks different three standard deviations from the norm.." Bernstein & Navot 2023



Schema Mode Therapy (in one slide)

Core Unmet Needs



```
graph TD; A[Core Unmet Needs] --> B[Formation of Early Maladaptive Schemas]; B --> C[Coping Strategies]; C --> D[Development of Mode States (Child, Coping Modes, Inner Critics & Overcompensating)];
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Formation of Early Maladaptive Schemas

Coping Strategies

Development of Mode States (Child, Coping Modes, Inner Critics & Overcompensating)



What are these fundamental emotional and psychological needs?

Every child has the same set of needs. These are the foundations for the healthy development of relationships, identity wellbeing. These needs are universal, and we never grow out of them, no matter how old we get.

We can categorise them as:

Attachment	Freedom
Play & Spontaneity	
Autonomy	Boundaries

Core emotional & psychological needs

Attachment	To be seen and heard To be understood To be validated To be loved and wanted To feel connected To feel safe and secure	Autonomy	Opportunities for independence to become our own person Opportunities for challenge and stimulation for growth Opportunities to develop competence in tasks Opportunities for self-development To receive constructive feedback
Freedom	To express how you feel or think To express what you like or dislike To ask for what you need or want To make choices To disagree skilfully	Play & spontaneity	Opportunities for fun and silliness Opportunity for self-expression Opportunity for exploration and adventure Opportunities for imagination and creativity Opportunities for the accumulation of positive emotions
Boundaries	To practise self control To be self-disciplined To take responsibility for our actions	To respect a response of NO from others To accept another person's right to safety, privacy, and space	





Why Forensic Schema Therapy?

Bernstein et. Al. (2007) Introduction of the concept of “schema modes” as distinct from “schemas”

1. **Schemas:** Enduring and stable patterns of beliefs, emotions, and behaviors formed through early experiences. Examples: Abandonment schema, mistrust schema.
2. **Schema Modes:** Temporary emotional states and behaviours that can change in response to situations
Function: **Represent the activation of one or more schemas in the moment**, influencing how an individual responds. Examples: Vulnerable Child mode, Angry Child mode, Healthy Adult mode.

Key Distinction: While schemas are stable, enduring patterns, **schema modes are flexible and context-dependent emotional states** that emerge from those schemas.

NEEDS UNMET	MALADAPTIVE SCHEMAS	NEEDS MET	ADAPTIVE SCHEMAS
Disconnection & Rejection	1. Abandonment 2. Mistrust/Abuse 3. Emotional Deprivation 4. Defectiveness 5. Social Isolation	Attachment	1. Stable Attachment 2. Emotional Fulfilment 3. Social Belonging
Impaired Autonomy & Performance	6. Dependence/ Incompetence 7. Vulnerability to Harm/Illness 8. Enmeshment 9. Failure	Autonomy	4. Competence 5. Developed Self 6. Success
Impaired Limits	10. Entitlement 11. Insufficient Self-Control	Realistic Limits	7. Empathic Consideration 8. Healthy Self-Discipline
Other-Directedness	12. Subjugation 13. Self-Sacrifice 14. Approval Seeking	Freedom to Express	9. Healthy Self-Care 10. Self-Directedness
Over-vigilance & Inhibition	15. Negativity 16. Emotional Constriction 17. Fear of Losing Control 18. Unrelenting Standards 19. Punitiveness - Others 20. Punitiveness - Self	Play & Spontaneity	11. Optimism 12. Emotional Openness 13. Realistic Expectations 14. Self-Compassion

Iceberg analogy schemas V modes

- Modes are in your face – what you see in the moment – the expressions, emotions, behaviours in the now – state based
- Schemas are underlying – the trigger for the mode
- Schemas are the cause / why for the mode's existence – but are often not in people's conscious awareness
- Modes are relatively simple for people to identify with
- Schemas are more complex concepts to grasp



Typical Mode Origins of Antisocial Behaviour

- **High stress family context**
 - Single mother / blended families / foster care
 - Parental psychological problems, mental illness, drug and alcohol problems
 - Parental criminality
 - Poverty
- **Exposure** to, and a victim of, physical, emotional and sexual abuse
- Early behaviour problems & mental health diagnoses (e.g. ADHD, Conduct Disorder, ODD)
- Poor educational attainment, learning disability, school exclusion due to behaviour problems
- Attachment rupture + insufficient limits





Typical Childhood themes

'It's a **dog-eat-dog world**' - vulnerability is weakness and weakness is exploited... (Mistrust / Abuse schema)

'**Live fast die young**' .. (Emotional deprivation, Insufficient self-control schemas)

'**To be safe I need to be feared**' (Mistrust / Abuse schema)

'**End justifies means**' (Entitlement schema)

When safe, nurturing attachments and stable supportive environments don't exist, or are inconsistent, the child eventually finds other ways to get their needs met

Origins of Forensic Modes

A **modeled strategy** that has practical utility in a dangerous environment

"My earliest memory was seeing my mother be raped by my dad... I was then also abused... when I went to the boy's homes, the older kids would get me, that happened, until I was the oldest and non-one could get me. I started raping the younger ones and it felt good to have control and power. In prison, rape became a strategy for control and power, not just pleasure although I enjoyed raping guys. I also knew that it scared the shit out of anyone who challenged me... You come for me, and I will get you eventually no matter what. I controlled everything." - Ray.

Prominent Modes: **Predator / Bully & Attack / Self Aggrandizer Modes**

Childhood Maltreatment and Personality Disorders (Lobbestael, Arntz, & Bernstein, 2010)

- Lobbestael et. al., (2010) investigated the relationship between five forms of childhood maltreatment: sexual, physical and emotional abuse, emotional and physical neglect and ten personality disorders (PDs)
- Child trauma increase risk of developing PD
- Results indicated that:
 1. **Sexual abuse was associated with symptoms of borderline PD**
 2. **Physical abuse with antisocial PD**
 3. **Emotional abuse with paranoid, schizotypal, borderline, and cluster C**
 4. **Emotional neglect with histrionic and borderline PD**



Personality Disorder (PD), Violence & Recidivism

Chow, et a. (2024) updated systematic review & Meta-regression analysis of link between PDs antisocial outcomes & recidivism

21 studies, **n =83 418**

Key finding 1: Increased risk of violence

- Overall elevated risk: Individuals with **any PD show a significantly increased risk of violence** compared to the general population (odds ratio 4.5).
- ASPD and BPD: Particularly **high risk for individuals with ASPD (OR 7.6) and BPD (OR 2.6).**





Personality Disorder (PD), Violence & Recidivism

Key Finding 2: Increased risk of recidivism

- Elevated risk overall: Individuals with any PD have a significantly higher risk of recidivism (OR 2.3).
- ASPD: Specifically, a higher risk for individuals with ASPD (OR 2.8).

Key Finding 3: Role of Substance Use Disorders (SUD)

- Role of comorbidity: Comorbid SUD significantly influenced the observed risk of violence; accounting for SUDs lowered the odds ratios.

Personality Disorder (PD), Violence & Recidivism

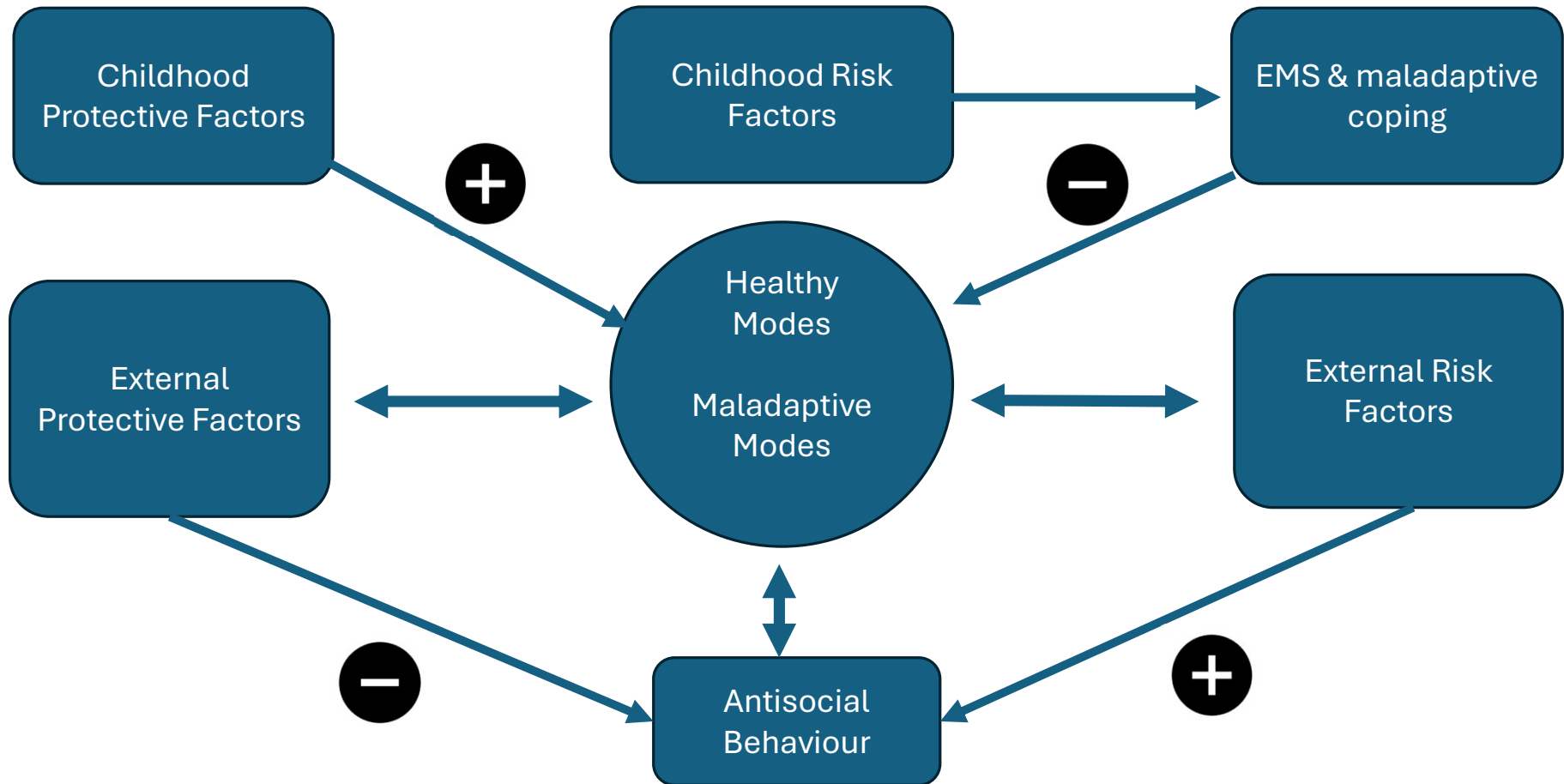
- Implications for Practice (Chow, et al, 2024)
 - **Routine assessment:** Emphasize the need for routine assessment and management of PDs, particularly ASPD and BPD, as part of violence prevention strategies.
 - **Address comorbidity:** Highlight the importance of addressing comorbid SUDs in treatment planning.
 - **Targeted interventions:** The development and implementation of tailored interventions based on *specific personality disorder traits*.

Why Forensic Schema Therapy (FST)?

The Risk – Needs – Responsivity* Model:

- Means that the ***rehabilitation approach should be adaptable and responsive to the unique circumstances of each offender*** to enhance the likelihood of positive outcomes
- Model used with range of offenders, including mentally-ill, intellectually disabled, female, and indigenous (e.g., Andrews & Bonta, 2010)
- FST represents a rehabilitative approach that aligns with the “responsivity principle” - it accounts for the unique challenges presented by forensic patients with Personality Disorder.

Explanatory ST Model for criminal & violent behaviour (Bernstein, et. Al., 2019)



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Core Unmet Needs of Forensic Patients

- VALIDATION/ACCEPTANCE
- **TRUST/SAFETY**
- SELF-SOOTHING
NURTURANCE
- STABILITY
- **HEALTHY LIMITS SET**
- SUPPORTIVE, CLEAR
DIRECTION
- APPROPRIATE BOUNDARIES
- LEARNING HOW TO TOLERATE
NEGATIVE AFFECT



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Schemas commonly present in Forensic Patients

1. **Abandonment/Instability:** Forensic clients often expect people will abandon them or leave, which can lead to clinging behaviour or, conversely, self-isolation or lashing out as a protective measure.
2. **Mistrust/Abuse:** There is often an expectation of harm or exploitation by others. This leads to heightened defensiveness, aggression, or withdrawal as means of self-protection.
3. **Emotional Deprivation:** Clients frequently feel that their emotional needs are unmet or that others are not empathetic, which can result in feelings of emptiness and attempts to fulfill these needs through antisocial means. It can also lead to 'super-independence' and a tendency to not rely on others or deny the need for support.
4. **Defectiveness/Shame:** A deep-seated belief in personal inadequacy or being unworthy, often leading to self-destructive behaviours or efforts to prove worthiness through control or domination of others. Broken, monster are common labels associated with this schema.



Schemas commonly present in Forensic Patients

5. **Social Isolation/Alienation:** Feelings of being different from others or not belonging, often leading to withdrawal and difficulties in forming social bonds.
6. **Failure:** A belief in inevitable failure, often resulting in giving up on goals or taking pathways that confirm these beliefs, such as criminal behaviour.
7. **Entitlement/Grandiosity:** An exaggerated belief in one's special rights and superiority, sometimes manifesting in manipulative or coercive behaviour entailing a disregard for others' rights.
8. **Insufficient Self-Control/Self-Discipline:** Difficulty in regulating impulses, emotions, or self-control, often leading to criminal acts as a means to satisfy immediate desires without considering consequences. Lack of goal-directed behaviour.





Schemas in Forensic Patients

- Schemas act like **'triggers'** emotional 'buttons' that once activated generate strong negative feelings
- Patients are **often not 'aware' of the schema as they will typically flip into a coping mode to regulate their experience** of the schema activation
- Understanding the client's history allows you to have a good idea of the schemas and also the unmet emotional needs

Forensic patient talking about
childhood and offending (Gary,
Dx. Psychopathy / ASPD)

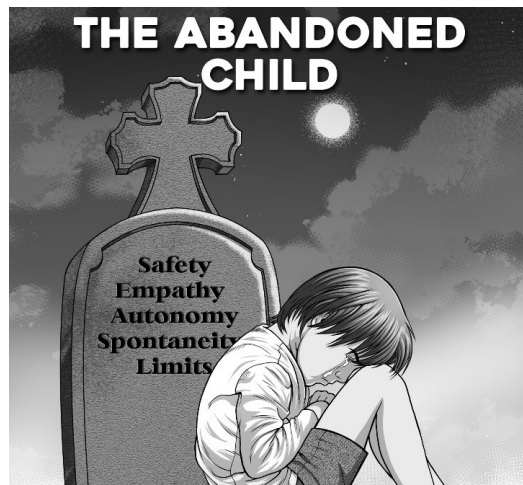


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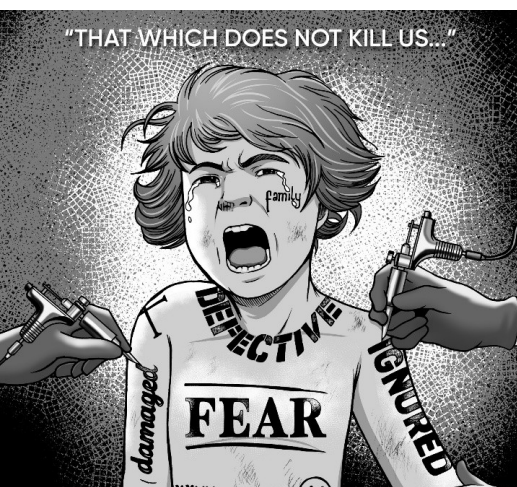
Modes

- Modes can be considered ‘parts’ of people – a side to their personality
- So, what do they look like?



THE ANGRY CHILD

feels uncontrolled anger in response to perceived mistreatment; acts like a child throwing a temper tantrum

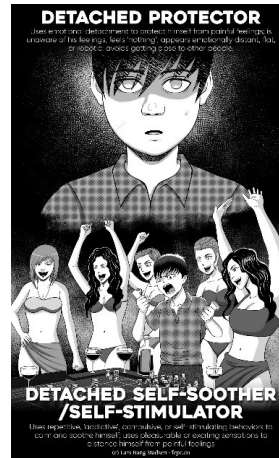
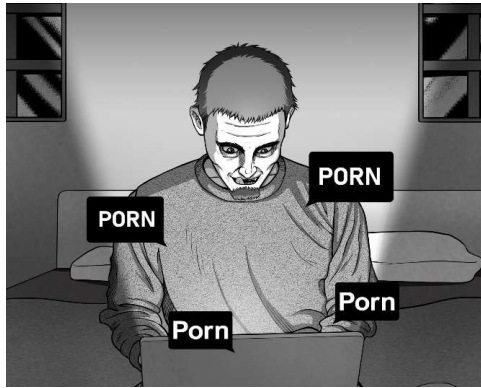


Child Modes: Original Activation – initial response to an activated schema

- Lonely Child (Abandonment, ED)
- Abused Child (Mistrust/Abuse)
- Lost, empty Isolated child (ED)
- Angry Child (ED, Entitlement)
- Shamed Child (Mistrust/Abuse)
- 'Frozen' Child (ED)

Linked to the schema being activated; where the client feels the pain and distress

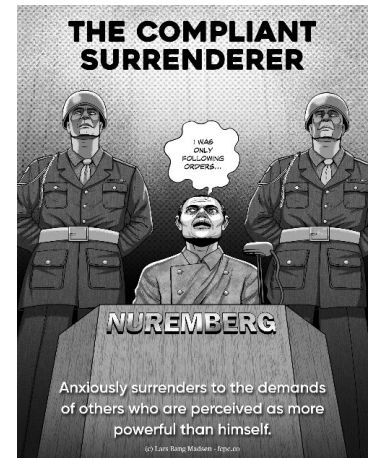
Avoidant Modes

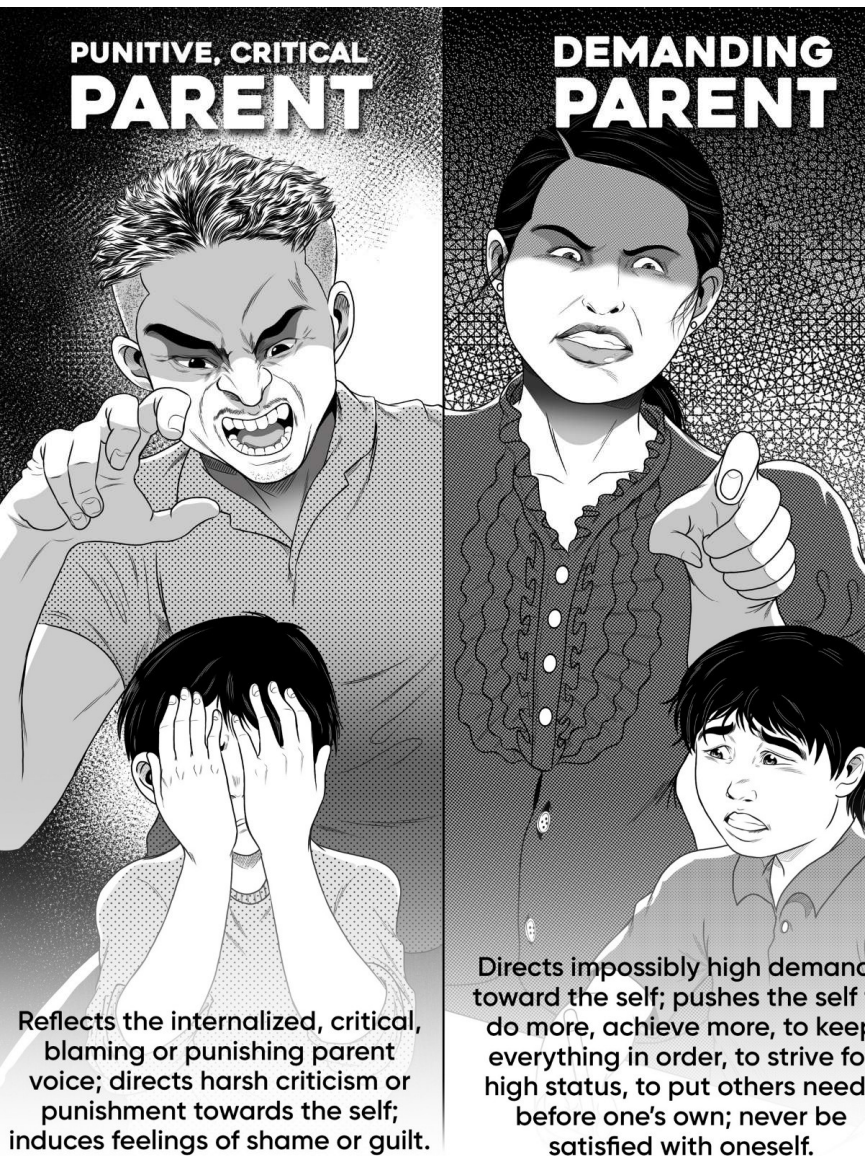


- Detached Self Soother – Stimulator / Protector
- Complaining Protector
- The Downloader
- The Angry Protector

Function:

- Avoid emotional pain, vulnerability
- Disconnect from Inner Punitive Critic



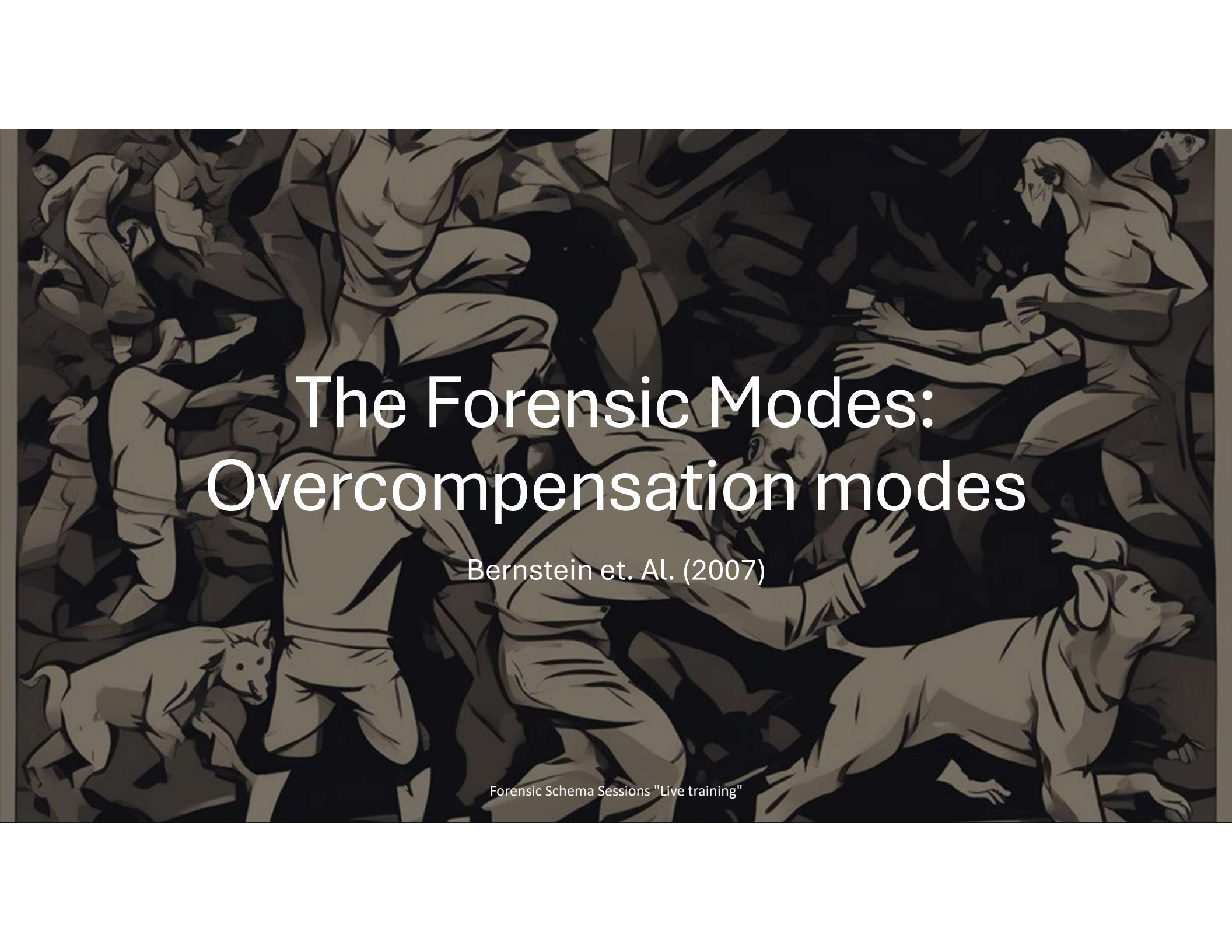


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Punitive & Demanding Parent Mode

internalized, critical or punishing parent voice; directs harsh criticism towards the self; induces feelings of shame or guilt

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The background of the slide is a dark, monochromatic illustration in shades of brown and black. It depicts a chaotic and intense scene with numerous figures. In the foreground, a man in a suit is being pushed or thrown by another person. To the right, a large dog, possibly a Rottweiler, is shown in a dynamic pose, possibly attacking or running. Other figures in the background are also in motion, some appearing to be in conflict. The overall style is graphic and somewhat abstract, with strong contrasts and a sense of movement.

The Forensic Modes: Overcompensation modes

Bernstein et. Al. (2007)

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The Bully & Attack Mode (Bernstein, et.al., 2007, 2019)

Key Signs

Presents in intimidating, threatening & aggressive manner –both verbally & non-verbally

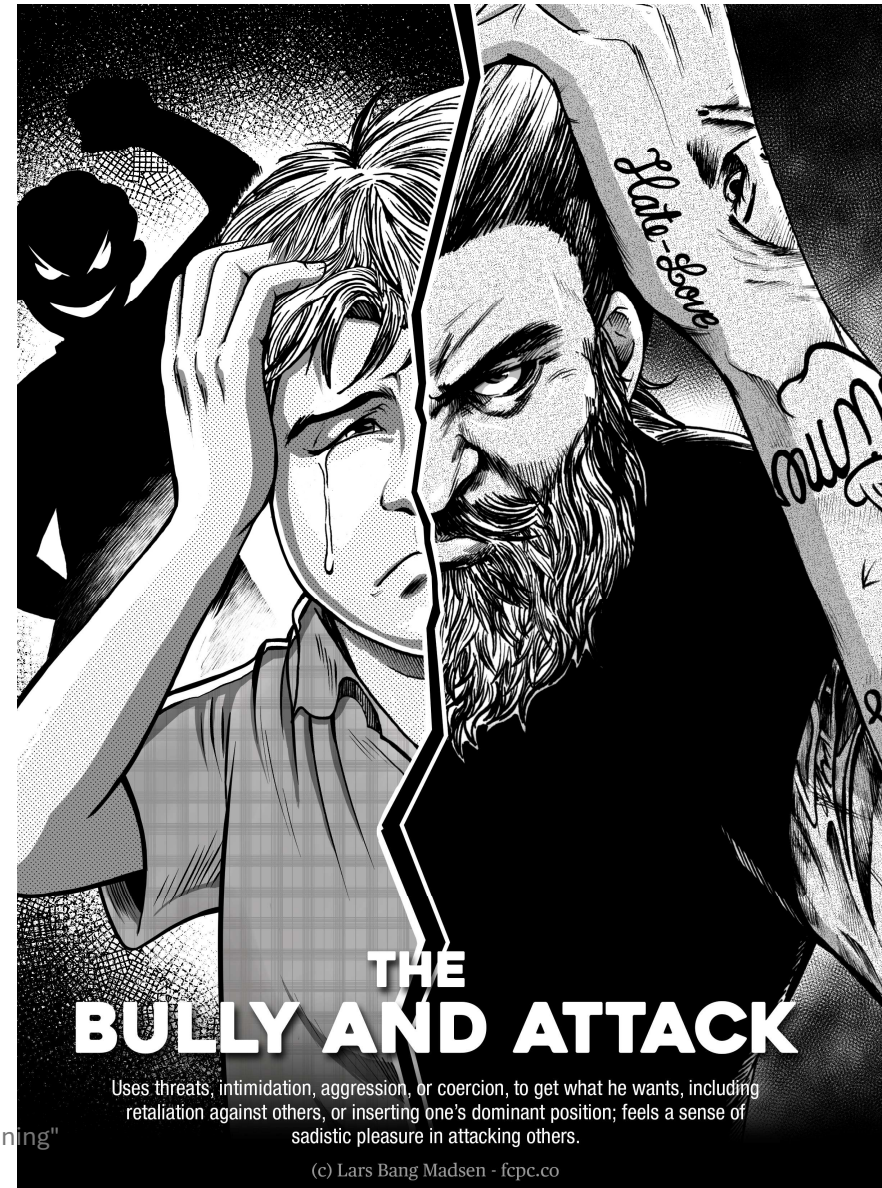
Objective of behaviours is to *put someone in their place, to make them feel unsafe or scared*

Different type of anger to angry child or angry protector - *targeted*

Function: Sometimes to overcompensate for feelings vulnerability, powerlessness, etc

Typical feelings: Scared, threatened, unsafe

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Pablo Escobar

<https://www.dropbox.com/scl/fi/a8o7eemdg1e7sugu7gt6y/Copy-Narcos.S01E01.XviD-AFG.avi?rlkey=zysyc1kxkpalqnffv4j25ong&st=hk1vn5d7&dl=0>

The Predator

(Bernstein, et.al., 2007, 2019)

Key signs

In this mode the patient is cold and detached and determined (THINK Jason from Friday 13th or Michael Myers in Halloween). Violence is cold and calculating. Different than bully & attack where the motivation to intimidate and threaten, the predator is orientated to achieving a goal or objective.

Instrumental violence

Debt collect / hit man 'just business'

Purposeful and controlled

Typical feelings: Scared, things aren't right, unsafe, the other person is unreachable



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Lars Bang Madsen - fcpcc.co

Anger in Antisocial Personality Disorder: A Predatory Perspective (Lobbestael, Arntz, & Bernstein, 2010)

Physiological Hyporesponsivity

Blunted Physiological Response to Anger

- Decreased heart rate and blood pressure during anger induction.
- Lower skin conductance responses (SCR) in some studies.
- Reduced facial expressions of anger (e.g., less frowning).

Cognitive Hyperresponsivity

Heightened Cognitive Processing of Anger

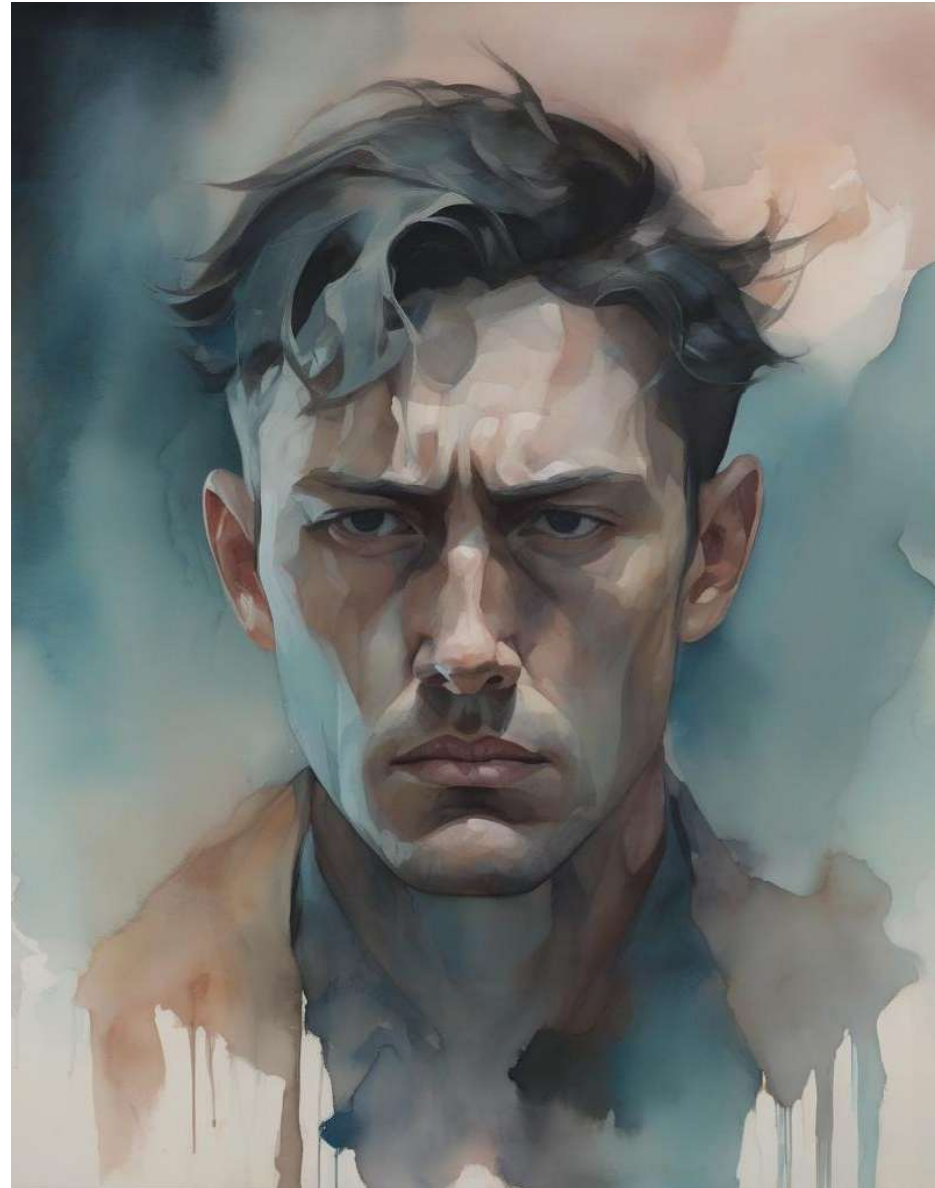
- Strong implicit associations between self and aggression (IAT).
- Instrumental aggression: Anger used as a tool to achieve goals.
- Rationalization and justification of aggressive behaviors.

Predatory-Like Anger in ASPD

(Lobbestael, Arntz, & Bernstein, 2010)

- Understanding Predatory-Like Anger
 - Calculated, not impulsive, aggression.
 - Focus on goal attainment, even if it involves harm.
 - Emotional detachment and/or callousness.
- Clinical Implications
 - Use multi-modal assessment (physiological, cognitive, behavioural).
 - Treatment targets underlying cognitive processes and strategies.

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The Self Aggrandizer Mode (Bernstein, et.al., 2007, 2019)

Key Signs:

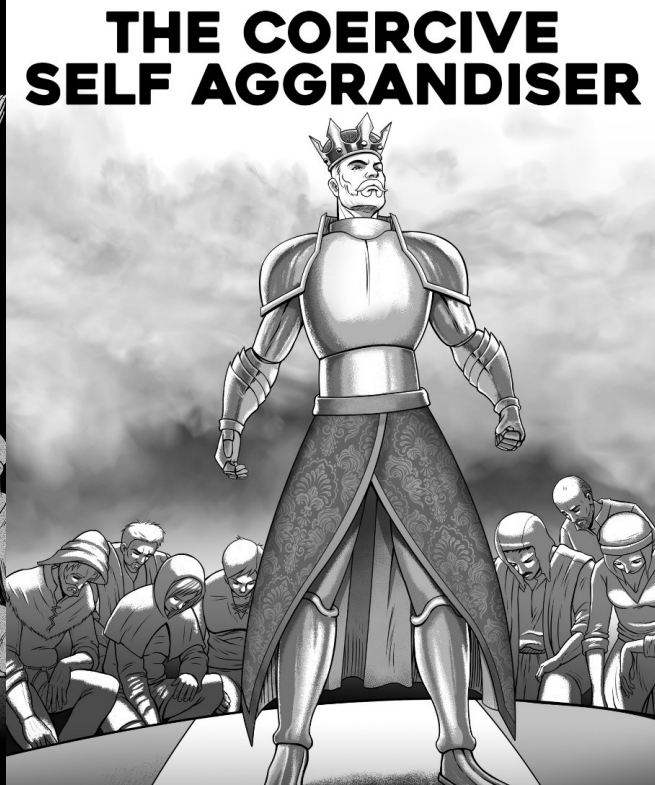
Likes to present self in a good light – tells stories about his specialness, superiority, normal rules don't apply to me

Experienced by others as arrogant, likes to talk about self

Puts others down, including the therapist, dismissive,

Function: Sometimes to compensate for feeling defectiveness, shame, worthlessness, feeling 'disrespected'. To reinforce status

Typical feelings: Annoyed, put-down / belittled, anxious to impress, intimidated



The Conning Manipulator mode

(Bernstein, et.al., 2007, 2019)

Key Signs:

Uses indirect methods to get what he wants. May present as a perfect patient, flatter the therapist and the therapy. May make up stories to garner sympathy including using their own trauma in an instrumental manner

May try to get favours, be owed something or encourage the therapist to violate boundaries in one way or another to have something over them

Lies

Typical Feelings: Confused, things don't add up, manipulated, slicked

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Suspicious & Paranoid Over-controller (Bernstein, et.al., 2007, 2019)

Key signs

Uses vigilance to protect, scanning other people for signs of malevolence

Hypervigilance

Attempts to protect oneself from a perceived or real threat by focusing attention, ruminating, and exercising extreme control in the environment

Always on the look-out or trying to locate and uncover a hidden (perceived) threat

Hostile attribution bias

Typical feelings: Difficult to connect with, over explaining, justifying, trying to prove yourself/rationalize

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Chaos Mode

- A self-destructive coping mechanism observed in forensic clients, particularly those with severe personality disorders, including psychopathy.
- Engages in self-harm and disruptive behaviors as a means of exerting control in oppressive prison environments.
- Creates a false sense of agency and victory over authority figures
- Behaviours provide short-term relief and a sense of pleasure despite being maladaptive and harmful.

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The Healthy Adult



I'VE GOT YOU...



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Where is the patient's healthy adult mode?

- **Dominance of the OC modes all other modes in service to it**
- Presence dependent on psychosocial history – early history of safe and/or positive attachment figures
- Therapist often must function as the healthy adult - modelling perception, interpretation, and response to criminal / antisocial behaviour

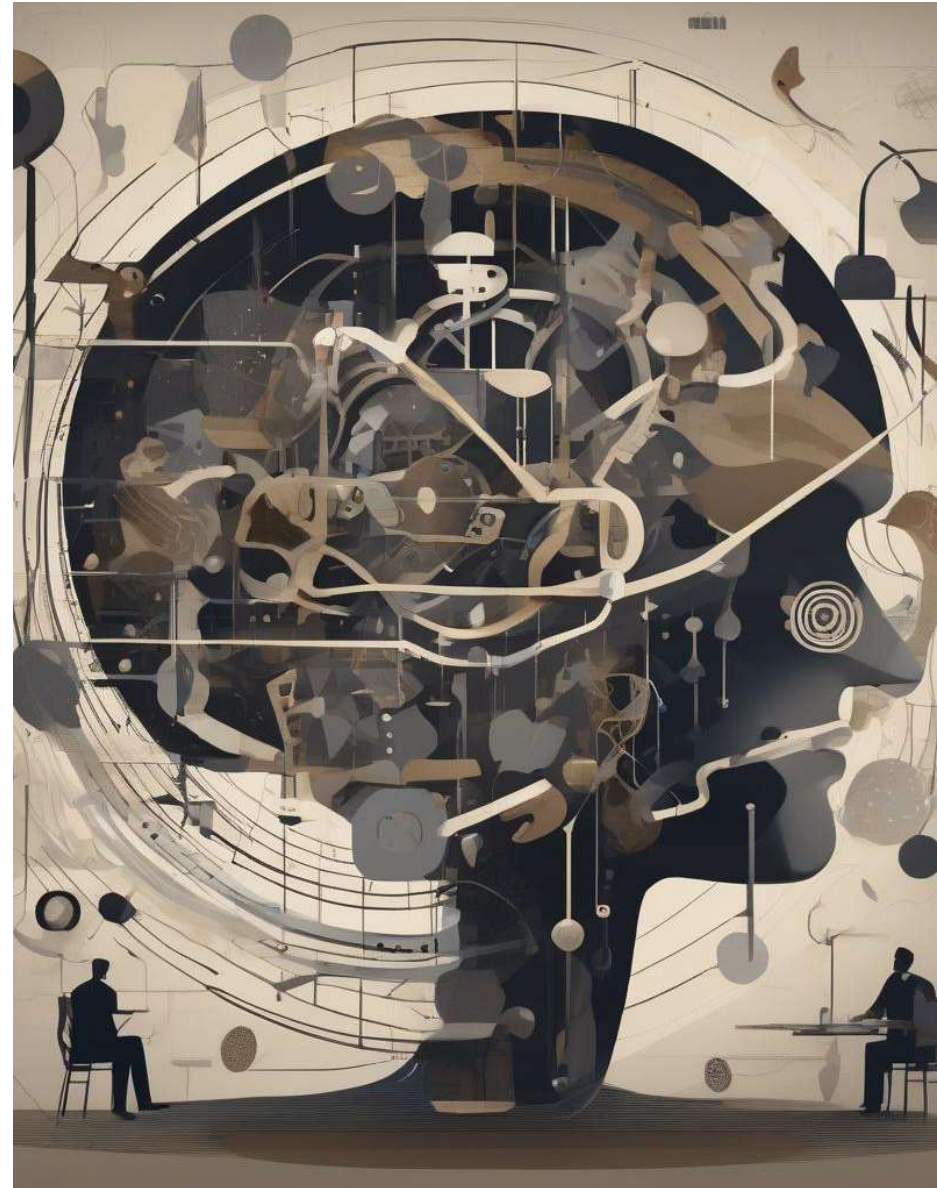
Common Schema Modes in Forensic Treatment

- 1. Detached Protector Mode:** Patients may exhibit emotional numbness and a lack of memory or opinion on topics. This mode serves as a defence mechanism to avoid vulnerability, resulting in detachment and minimal engagement in therapy.
- 2. Complaining Surrenderer Mode:** Characterized by relentless complaining, often about therapy or external issues. Patients express chronic dissatisfaction, reflecting feelings of helplessness and resignation to their perceived shortcomings or circumstances.
- 3. Angry Protector Mode:** Patients often present as surly, difficult, and defensive. This mode arises as a protective response to perceived criticism or threat, manifesting as hostility toward the therapist to maintain a sense of control.

Common Schema Modes in Forensic Treatment

- 4. Conning Manipulator Mode:** Patients appear overly cooperative or motivated, yet their engagement may feel insincere. This mode uses charm or deceit to manipulate the therapy process, masking true intentions and vulnerabilities.
- 5. Undisciplined Child Mode:** Patients show impulsivity and lack of self-control during sessions, often struggling to adhere to therapeutic tasks or boundaries. This mode reflects difficulty delaying gratification and managing impulses.
- 6. Abused Child Mode:** Exhibits signs of extreme vulnerability, fear, or mistrust. Patients in this mode may express feelings related to past trauma or abuse, displaying behaviours that indicate unresolved pain and hypersensitivity to betrayal.

Forensic Schema Sessions "Live training"



Common Schema Modes in Offending

- 1.Impulsive Child Mode:** Driven by a need for immediate gratification, leading to spontaneous and reckless crimes without forethought or consideration of consequences.
- 2.Angry/Enraged Child Mode:** Characterized by intense anger resulting in aggressive or violent acts as a reaction to perceived slights or provocations.
- 3.Bully and Attack Mode:** Aggressive and intimidating behaviour used to dominate or control others, often through threats or actual physical harm to assert power.
- 4.Conning Manipulator Mode:** Involves deceit and manipulation to achieve goals or avoid consequences. Offending behaviour in this mode features strategic planning and convincing others of false intentions, often leading to fraudulent or exploitative activities.



Common Modes in Offending

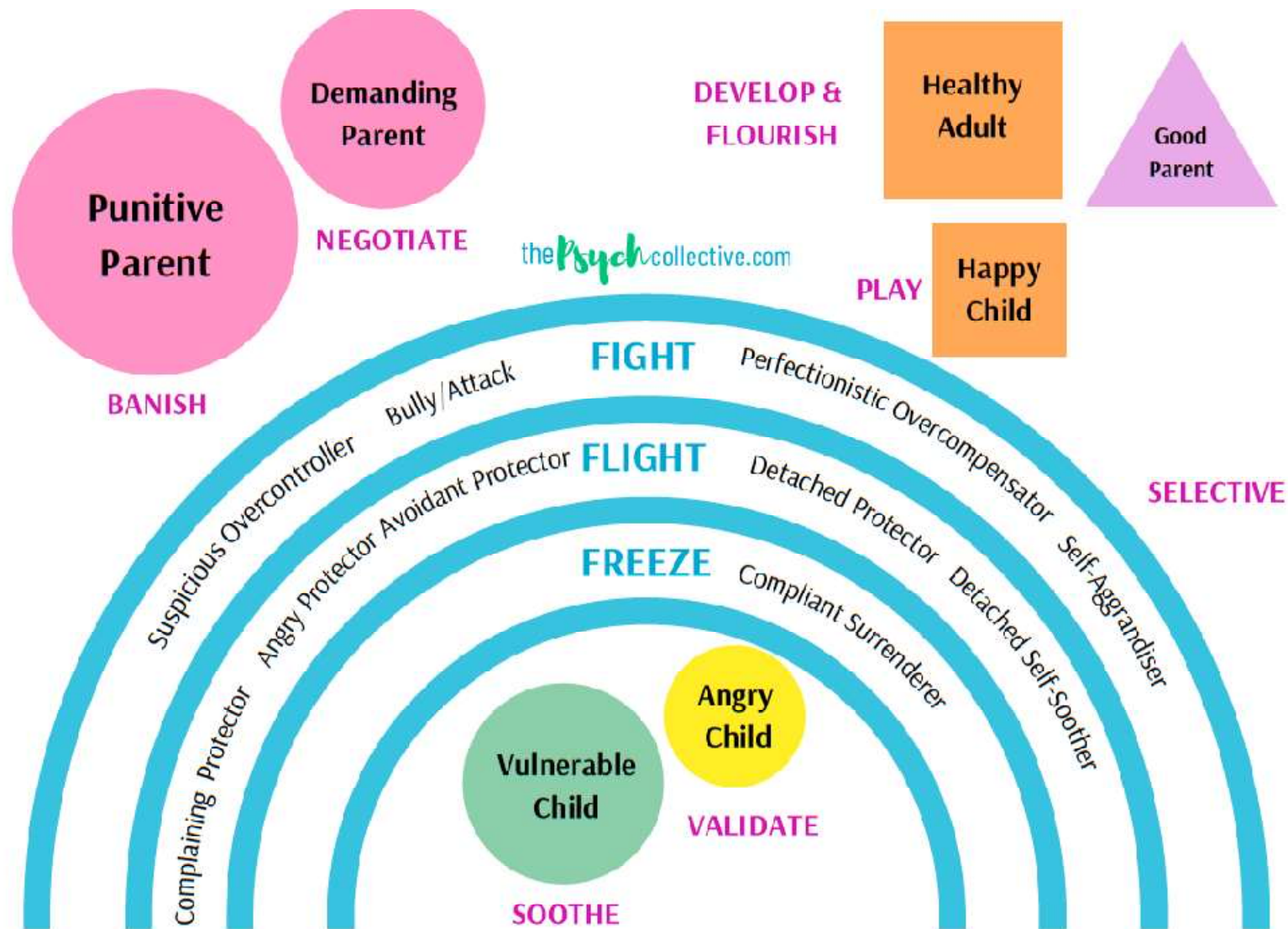
- 5. Predator Mode:** Represents calculated, strategic, and exploitative offenses targeting vulnerable individuals, driven by a sense of superiority and entitlement.
- 6. Self-Aggrandizer Mode:** Offenses are committed to reinforce self-importance, often through acts that highlight perceived superiority or exceptionalism over others.
- 7. Paranoid Over-controller Mode:** Offenses arise from excessive control and vigilance due to paranoia and mistrust, leading to pre-emptive or defensive actions to neutralize perceived threats.



Forensic Schema Sessions "Live training"

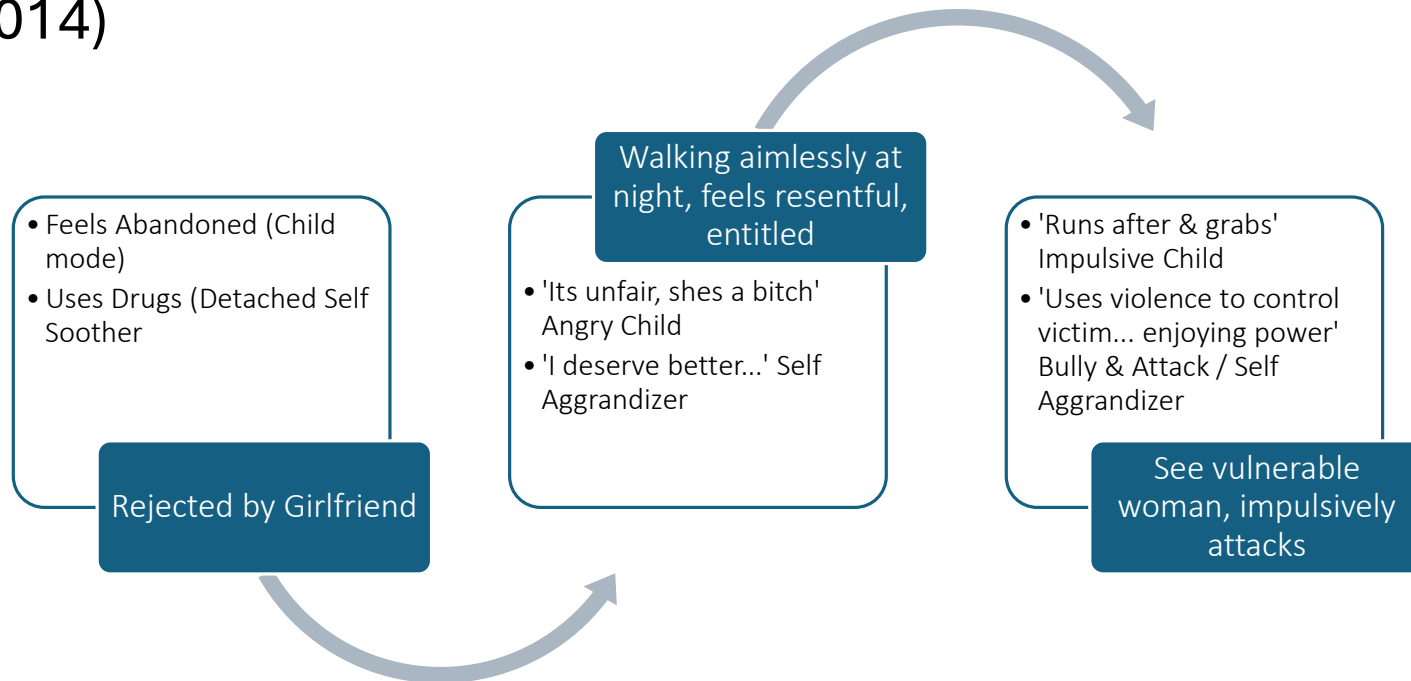
Adaptations of ST for Forensic Patients

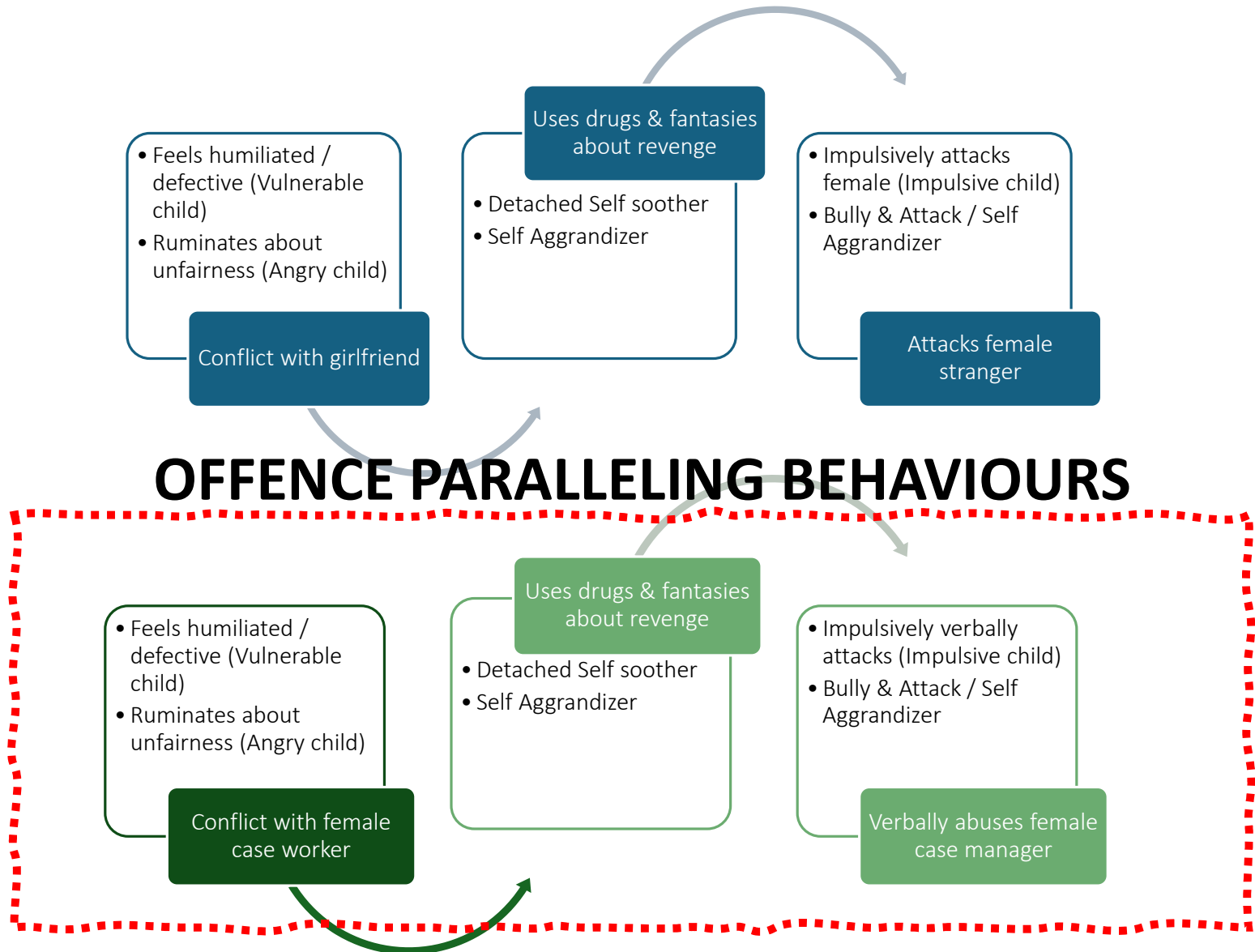
- Greater focus on Modes rather than schemas
- Working in the **‘here and now’ with frequent mode flips between intense emotion, detachment and other problematic behaviours**
- **Early therapy goal in therapy is developing a mode map** of the patient and being able to “make sense” of offending behaviours using mode mapping



Offending & Modes Flips

- FST understands offending as an unfolding sequence of modes, usually initiated by a vulnerable / child mode (Keulen-De-Vox et al., 2014)







The value of knowing modes in risk assessment

- Structured risk assessment can only say so much, and the challenges with is identifying when someone is most at risk
- The **presences or absences of Modes can be indicative of risk** (dynamic)
- **Dynamic variables are used many risk assessment instruments** including the DASA, HCR-20, RSVP etc.

Case conceptualisation

- Victor (43 years) referred due to risk assessment outcome and impending parole application
- Convicted of Murder plus History of Violent Crimes
- Diagnosed - **Antisocial Personality Disorder with Narcissistic & Borderline** traits plus unspecified **Paraphilic Disorder**
- Substance Misuse Disorder, in remission in confined context
- Psychopathy Checklist Revised (PCL-R) 25 (Hare, 2003)
- Risk of Sexual Violence Protocol (RSVP) = high risk

Case Study Example

- Grew up in foster home with large number of other children
- Foster parents **emotionally & physically** abusive (mistrust & abuse, emotional deprivation)
- From a young age felt different in a negative way (failure / defectiveness), was excluded by peers
- Drug, alcohol abuse early on
- Sexual preoccupation – porn use, 'peeping tom'
- Stalking, risk taking & violence used to get needs met

Victor

Temperament:

Bold, daring

Childhood experiences

Was placed into foster at birth

Grew up in a big family

Foster Parents were emotionally and physically abusive

Atmosphere at home was one of fear 'walking on egg-shells'

Little warmth, connection and attunement

From young age was allowed to wander around neighborhood by himself

Exposure to antisocial older peers / drug and alcohol abuse

Unmet needs: Lack of safety, protection, empathy, nurturing and attunement, provide no help with coping with problems

Schemas:

Defectiveness and Shame: **I am a freak, and I don't belong**

Mistrust and Abuse: **People hurt and exploit you**

Emotional deprivation: **Don't expect anything from anyone** – love, understanding, guidance

Social Isolation: **I am outcast**

Abandonment: **People always leave**, and I will be alone

Subjugation: **You must yield to others, or you will be punished**

Bully & Attack

I'll take what I want – no one can stop
I'll willing to go to extreme levels of
violence to prove my point – using
intimidation and threats

Self-Aggrandizer

I will have power and control of others
I **stalk** people and could take them at any
time – I have that over people
Takes things from others because he
knows he can and they will not stop him

Predator

I will **destroy** people – stalks people

Punitive Mode:

You are pathetic, weak
You're toxic to everyone,
You will never have a relationship or
sexual fulfillment
You are defective and disgusting

Avoidant Modes

Detached Self Soother / Self
Stimulator
Takes drugs and uses sex to
feel nothing
Watches 'mindless' tv / eats

Detached Protector

Feels nothing cut off from
feelings

Little Victor

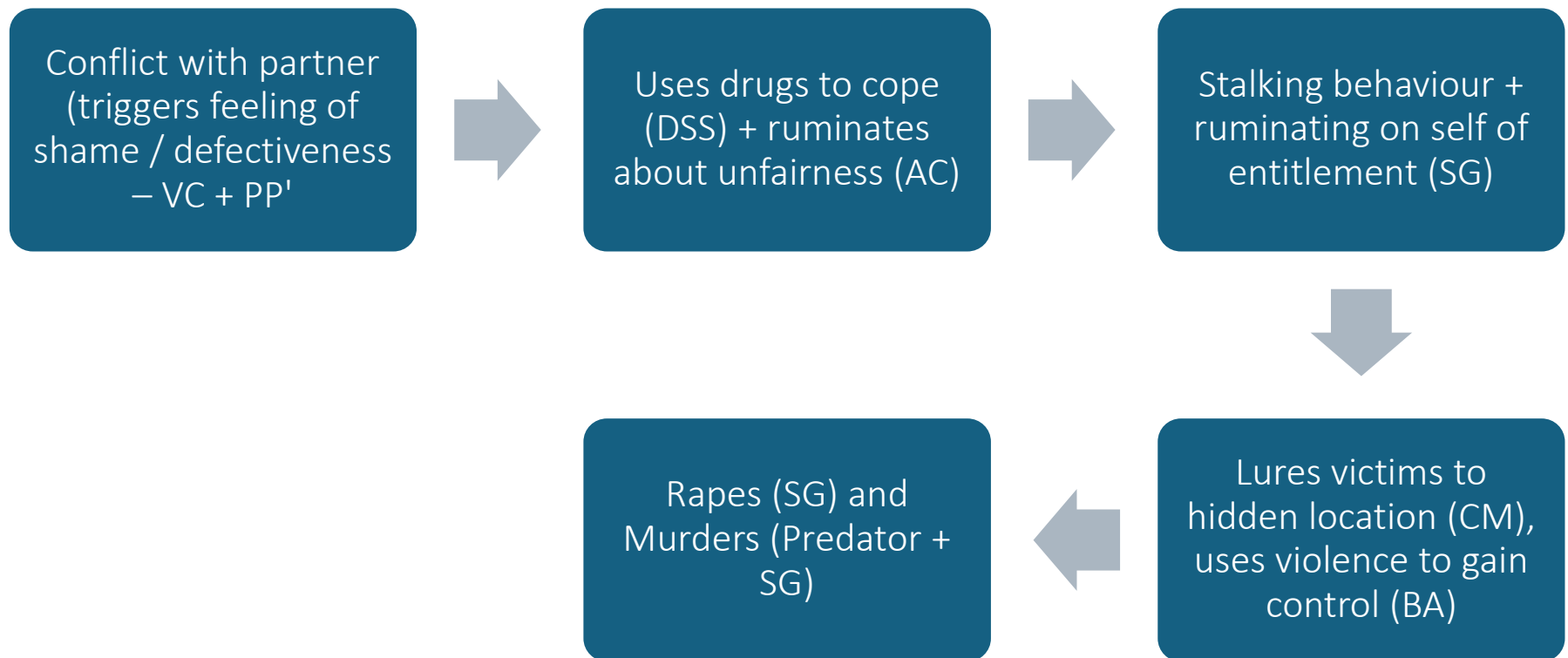
Anxious, lonely, feels
scared, hopeless and sad

Angry & Impulsive Child

Feel angry about being
treated poorly

Yells, throws things , does
things on an impulse –
quits a job, gets into a
fight, etc

Offending Mode Sequence



Case example

- Function of offending
 - **Overcompensation** for a sense of powerlessness, defectiveness, exclusion and failure:
 - "The *peeping tom* behaviours made me feel relevant, powerful and capable. It was important that they did not know I was there ”
 - "The feeling of power of having something over someone else and I could do anything to them, and they could not stop, was powerful. It made me feel like a type of god"

Goals of Schema Therapy with Forensic Clients

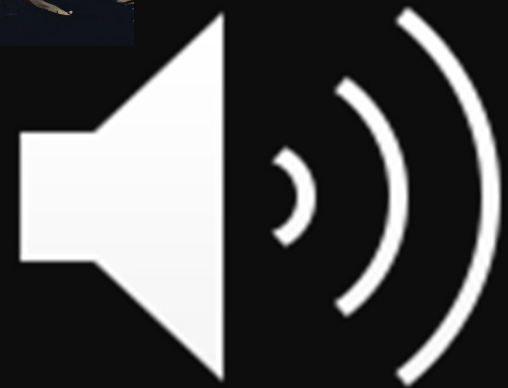
(Bernstein et al., 2007, 2019)

- Reduce **risk of reoffending (PRIORITY)**
 - Offending is conceptualised in terms of **MODES and MODE SEQUENCES**
 - Risk is understood in terms of **PRESENCE or ACTIVATION of Offence-Related Modes**
 - Offending Modes are never considered to be eliminated, **they are only managed and contained**
 - **Similarly, RISK is never considered zero**
- **Improve HEALTHY ADULT** functioning and presence
 - Assist client get his core emotional needs met in ways that do not put himself or others at risk of harm
 - Healthy Adult acts as protective factor

Identifying the mode: questions to ask yourself

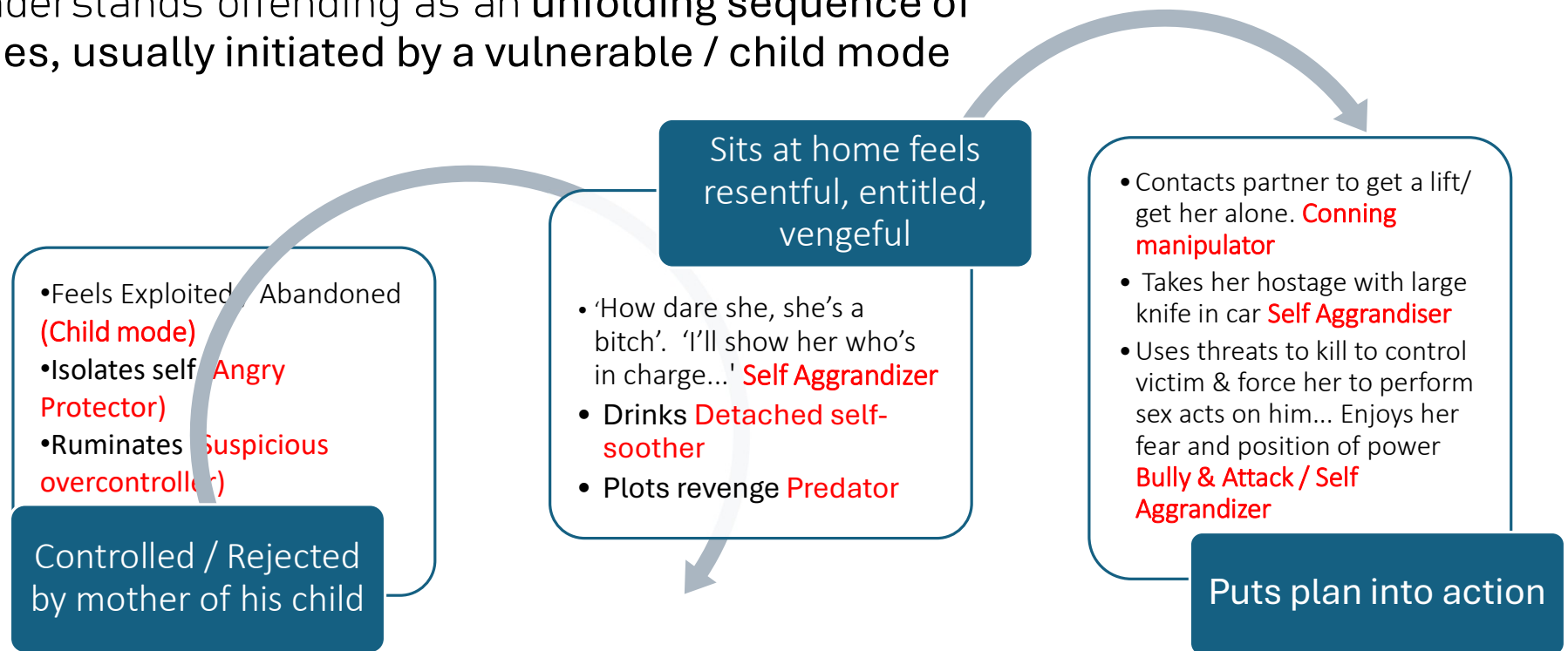
1. What are you noticing in the “here and now”?
2. What do you observe about the patient’s emotional state (e.g. no visible emotion, appears tense, angry, sad, or fearful? What is the mode’ primary emotion?
3. What might have triggered the mode?
4. What might the patient be thinking?
5. What is the patient’s coping style? E.g. withdraw, dominate, becomes submissive
6. How do you feel when the patient is in this mode?

Develop Mode Sequence and Mode Map



Making sense of offending: Grievance violent offender, Henry

ST understands offending as an unfolding sequence of modes, usually initiated by a vulnerable / child mode



OVERCONTROLLER MODES

Suspicious overcontroller

Replaying all past conversations / actions / r'ship issues in his head; Reinterpreting past interactions
Hyperfocus on details. Sees threat everywhere

Self-Aggrandizer

She's not going to get it over me. I will NOT be overpowered by others
She doesn't know who she's messing with
Nobody treats me like that

Predator

I will **destroy** people who have hurt me
She **has it coming** and **deserves what she gets** for fucking with me. Contemplates murder.

Conning Manipulator

Plans how to isolate victim without her becoming suspicious. Plays nice to get a lift with her

Bully & Attack/Self Aggrandiser

Feels superior and in charge. Enjoys power gained through threats to kill with knife. Toys with her and forces her to do acts against her will.

Compliant surrenderer mode

No-one is coming
I can only rely on myself

AVOIDANT MODES

Angry protector

Isolates self
Hostile rumination

Detached self soother / stimulator

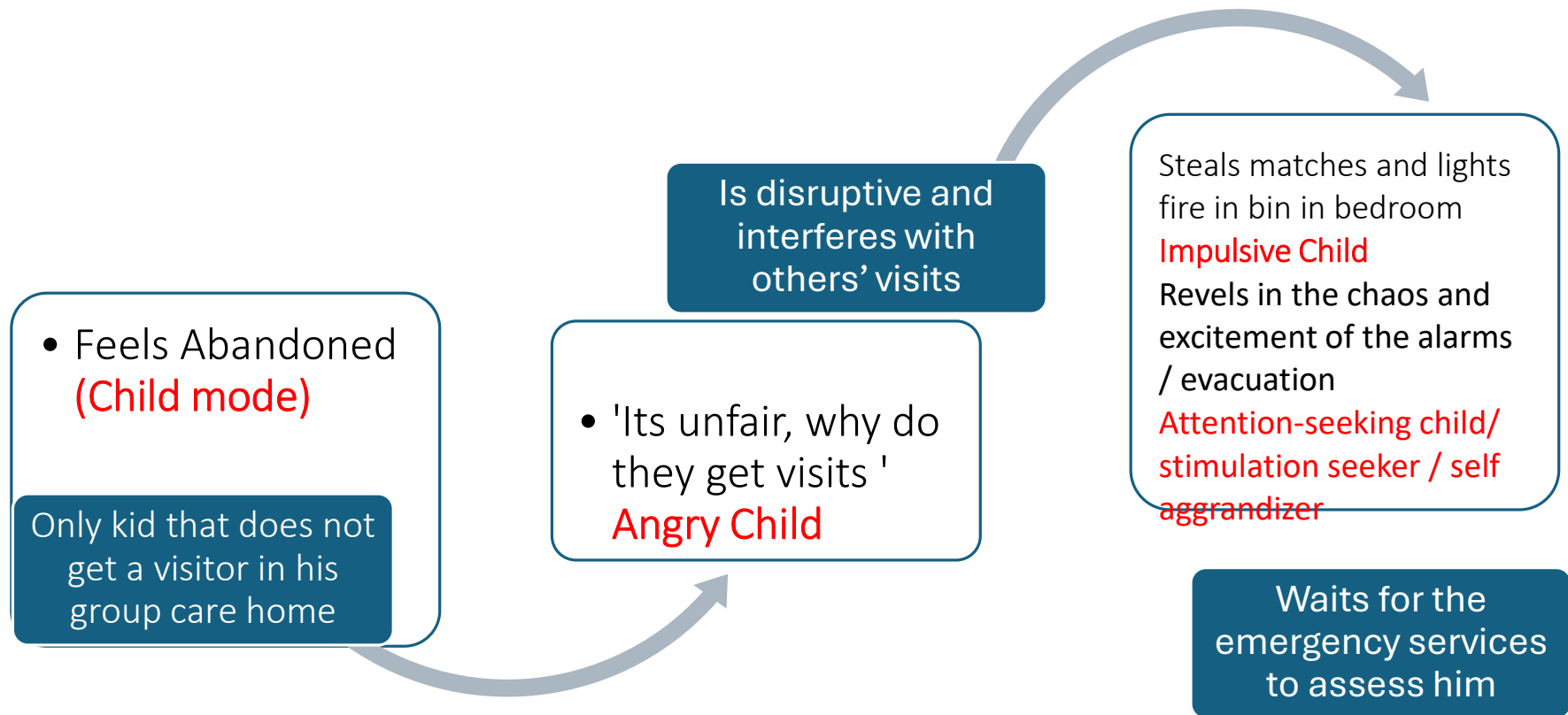
Drinks alcohol

CHILD MODES

Vulnerable Abandoned Lonely Little H

Feels abandoned, feels overpowered and exploited. (extreme emotions)

Making sense of offending: **Fire Setting**, Charlie



MODE MAP, CHARLIE

OVERCOMPENSATING MODES

Self-Aggrandizer

Getting on top, game playing. I'll have the last laugh.

Chaos mode

Revels in creating maximum drama in the environment, and seeing how the stress plays out for people he feels shunned him / ignored him.

CHILD MODES

Abandoned / lonely child

Alone, lonely, defective.
(extreme emotions)

Angry Child

Feels angry about being treated differently, missing out

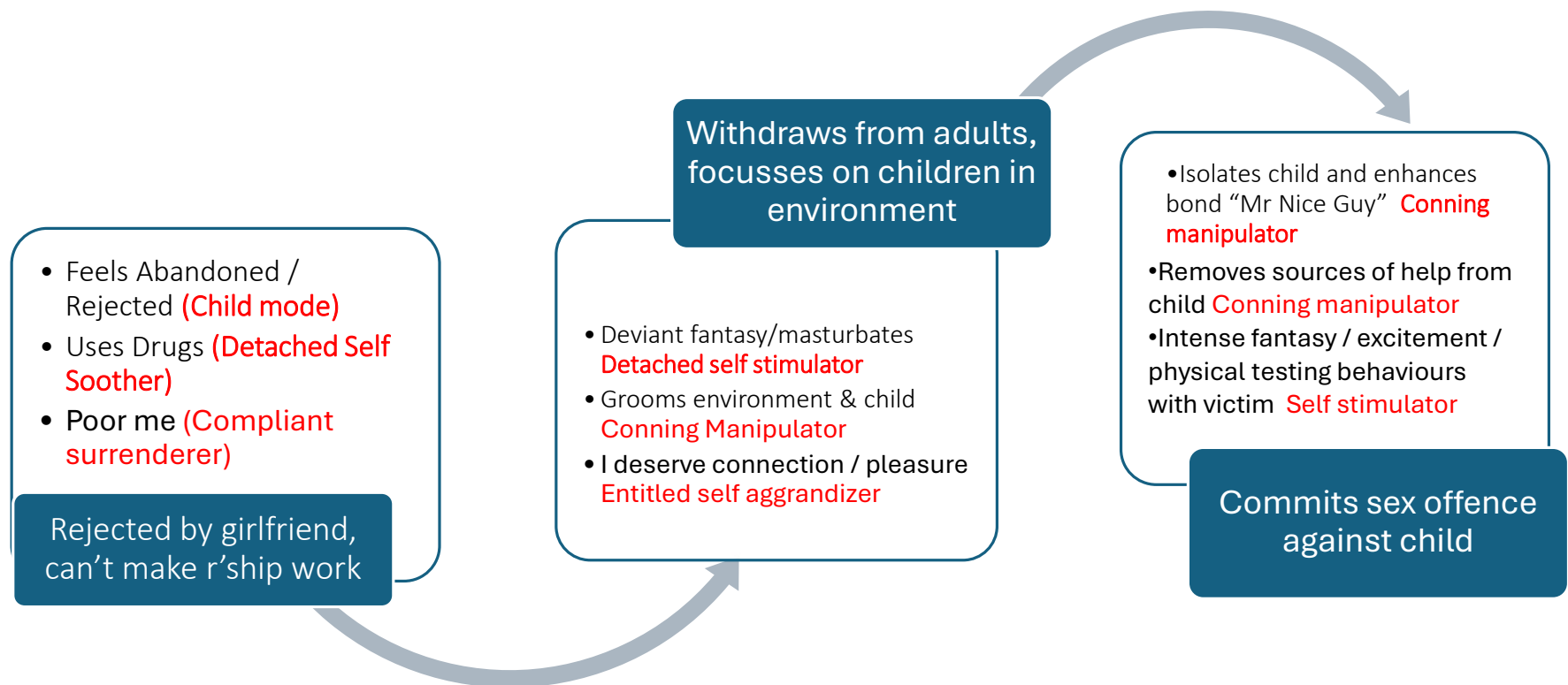
Impulsive undisciplined child

Acts on feelings without thought of consequence

Attention-seeking child

Engages in extreme behaviour to get noticed

Making sense of offending. Paedophilia, Chris



OVERCONTROLLER MODES

Paranoid overcontroller

Hypervigilant to harm and perceives environment as harsh and dangerous

Conning “Master Manipulator” / Chess Player

Superficial compliance. Pleasant, knows what to say to staff.

Exploits opportunities in his environment

Generates cover story, covers his tracks and lies convincingly. Cons target (female child/ parent) & environment

“Nice guy” – says all the right things.

Self-Aggrandizer

Getting on top – cleverer than everyone else – enjoys getting one up – the game. I deserve it. They deserve it.

Compliant surrenderer

What’s the point of trying? I’ll never get anywhere. Hopeless future.

Everyone thinks I’m just a dirty pedo who’ll never change

I can’t handle this any more / disengages from systems

Avoidant Modes

Detached self soother / stimulator

drugs / masturbation / deviant fantasy

Moves towards pleasure / intimacy seeking

Complaining protector

Relives all the small injustices, repeats details of unsatisfactory encounters

Focusses on unfairness

MODE MAP - CHRIS

Punitive Parent mode

I’m fucked in the head
Nothing can save me

Child Modes

Vulnerable Little C

Frightened, alone, desperate, lonely, defective, inadequate.
(extreme emotions)

Angry Child

Feels angry about being treated poorly, lack of care, rejected

Role Play: Using the language of parts and sides in an interview with forensic patient

Groups of 2 or 3, Use a forensic client or the provided case example. One person be the patient being interviewed and the other the ST interviewer:

Interview about history of violence and other maladaptive 'schema mode' behaviours

A black and white photograph of a person walking up a long, dark staircase. The person is silhouetted against a bright light source at the top of the stairs, creating a strong backlight effect. The staircase is flanked by dark, textured walls. In the background, a multi-story building with many windows is visible. The overall mood is one of ascent and hope.

Getting Started

Schema Therapy with Forensic Patients

Forensic Schema Sessions "Live training"



1. Attachment Phrase: Key Characteristics

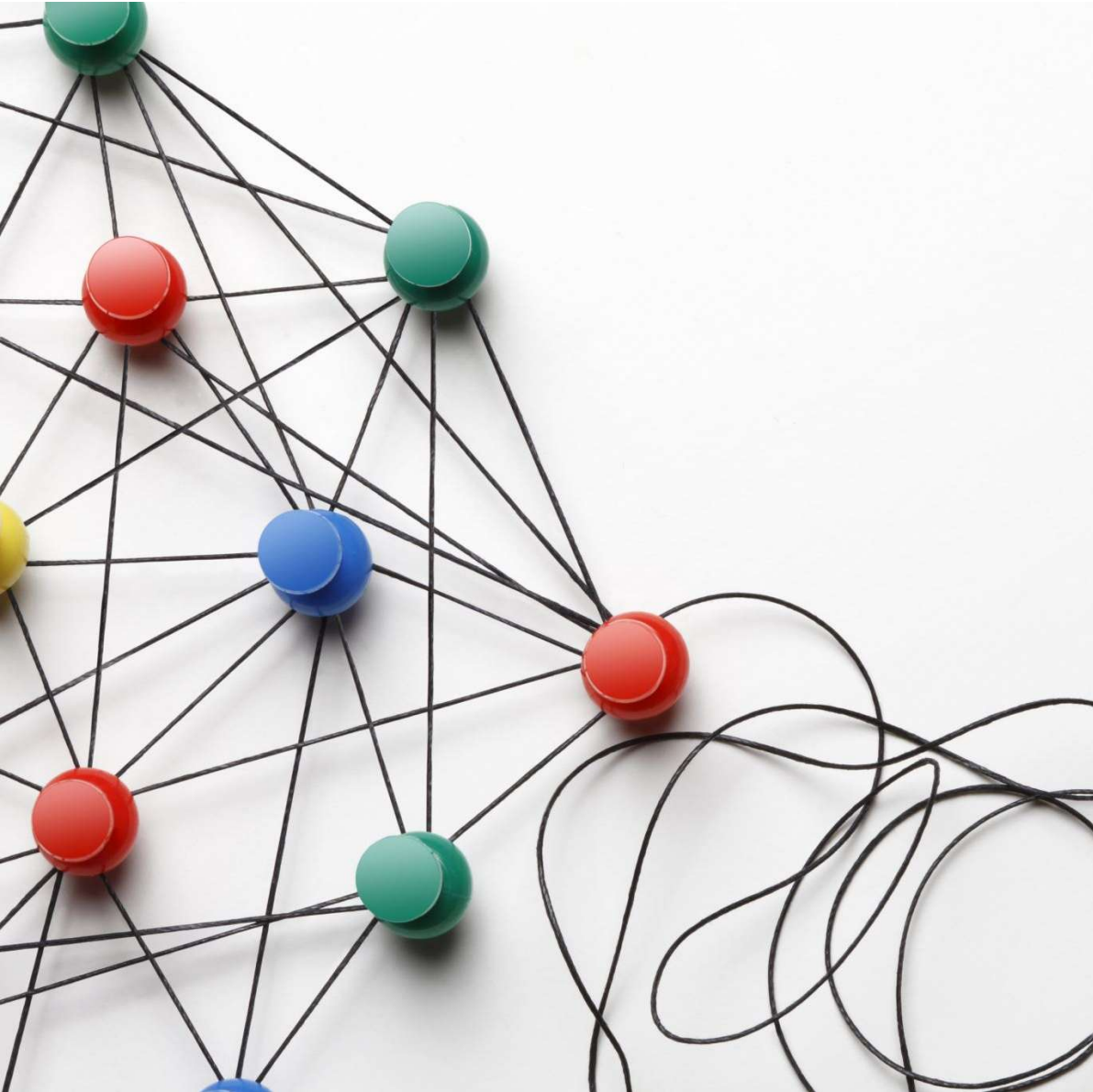
- Key goal to motivate & engage patient
- Provide **psychoeducation** regarding modes & schemas
- **Identify** the modes that are relevant in the therapeutic process (develop mode map)
- Have orientation to patient's unmet emotional needs (**limited reparenting**)
- Use **empathic confrontation** with maladaptive coping modes
- Progress achieved when patient is:
 - Increasingly involved in the therapeutic process
 - Is aware of modes -> less active in session



This Photo by Unknown author is licensed under CC BY-SA.

2. Reprocessing Phrase: Key Characteristics

- Use of **experiential techniques**, such as imagery, re-scripting, etc.
- **Access traumatic early memories** linked to formation of schemas/modes
- Explore **pros & cons** of coping modes (cognitive)
- Identity & **challenge cognitive distortions** (cognitive)
- Identify health adult mode characteristics & behaviours



3. Reintegration Phrase: Key Characteristics

- Focus on **behaviour change** and **relapse prevention** (Chakhssi, et. Al. 2014)
- Chain analyses used to **identity triggers & escalating mode sequences** that reflect the patients offending pathway --> aim to break the chain
- **Behavioural rehearsal** – trying out new behaviours in circumstances that triggers schemas
- Risk behaviours or set-backs seen as opportunity to learn
- Session frequency reduced and eventually terminated

Getting Started: Common Pitfalls

1. Assuming patient will be intrinsically motivated to change or engage meaningfully in therapy
2. “Love is all that matters”
3. Assuming that patients understand the system and their situation
4. You don’t understand the system or the patients legal/institutional situation

Mindset: Top Tips Starting

1. “Context is King”
2. Be honest Always
3. Genuinely commit to the journey
4. Patience and pacing is critical – titration of the intensity of the therapy

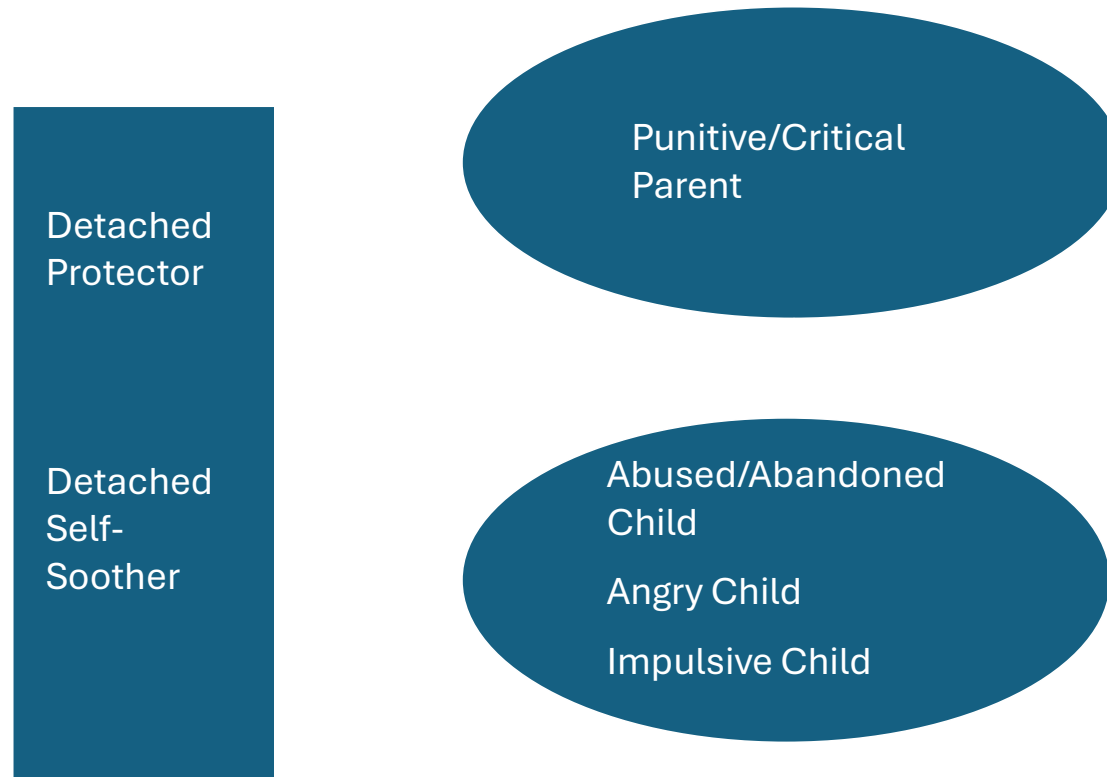


Assessment Components

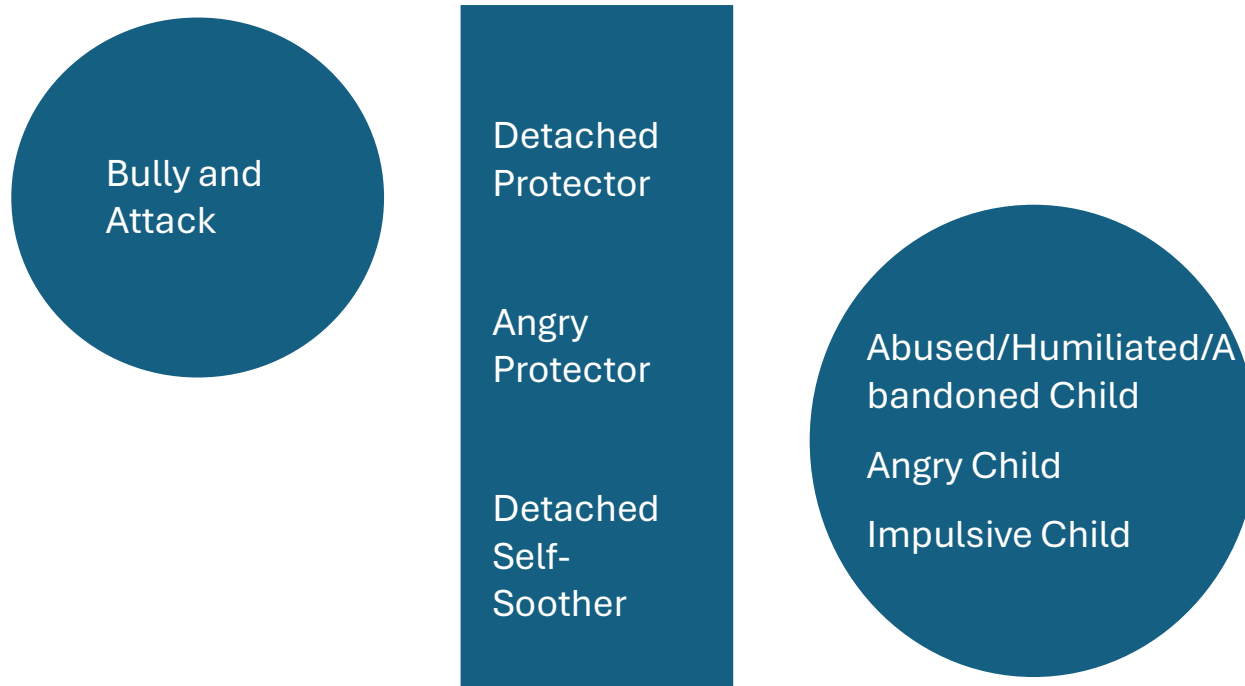
- FULL BIOPSYCHOSOCIAL HISTORY (consider also using the IPTE)
- Risk Assessment & Personality (PCL-R/SV; IPDE)
- ST Assessment Tools (YSQ and SMI)
- Imagery for assessment
- Therapy Relationship central tool
- Mode Map, Mode Cycle and Key Modes

Before meeting the patient you can start to construct a possible MODE MAP based on previous DX and documented histpry

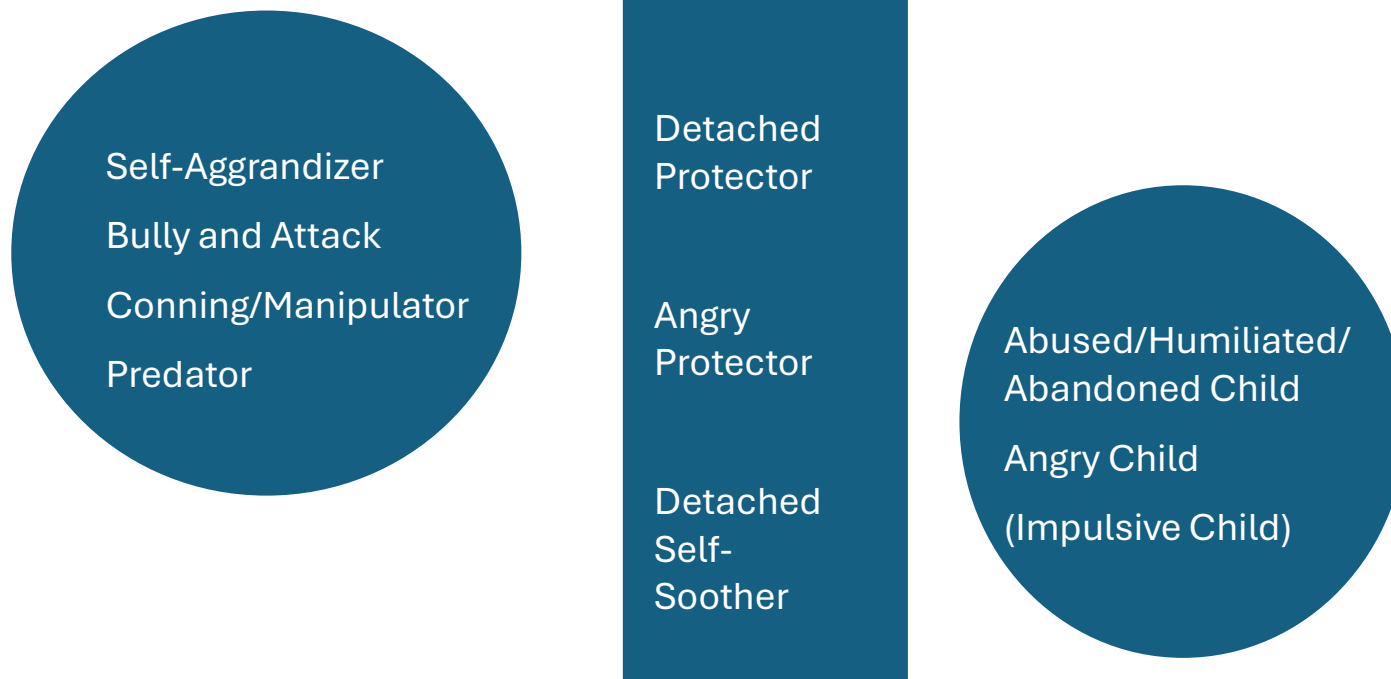
Borderline Personality Disorder



Antisocial Personality Disorder (Impulsive/Aggressive, non-Psychopathic)



Psychopathy



Working in the *Here and Now* identify modes

- Introduce use the language of sides and parts:
“Sounds like there is a part of you That needs to be safe / on-top / watches out for danger ”
- Exploring **emotional reactions and functions of sides:**
“*Sounds like this part of you makes sure you don’t get hurt ...*”
- Introduce Emotional Needs (safety, empathy, autonomy, etc)
- Telling the story of the modes, why it came about, the need, the function **(IT MAKES SENSE IN THE CONTEXT OF YOUR LIFE!):**
“*Sounds like this part came about because you weren’t safe when you were a child*”



Working with Modes

Always make sure to validate the mode, to acknowledge that it serves an important function in the patient's life, even if it has sometimes caused him problems



Day 2: Key Problems, Challenging Modes & Experiential Exercises

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A dark, atmospheric landscape with a winding road. The road is paved and curves through a dark, scrubby terrain. The sky is filled with heavy, dark clouds, suggesting an approaching storm or late evening. The overall mood is somber and mysterious.

The Therapeutic Relationship

Forensic Schema Sessions "Live training"

Finding Hope and Purpose (for you and your client)

- Meaning is constructed through **narratives**; without meaning, individuals may struggle with mental health (Frankl, 1985).
- In forensic settings, clients often experience fragmented narratives due to trauma, offending behaviour, or institutionalisation (Maruna, 2001).
- Schema therapy targets maladaptive coping patterns by integrating narrative techniques to promote identity coherence and purpose.



"The hero's journey is a transformative adventure where an ordinary individual faces challenges, overcomes trials, and returns changed, bring newfound wisdom to enrich their world"

Joseph Campbell

The Hero with a Thousand Faces



Limited Reparenting is a therapeutic technique aimed at addressing unmet childhood needs by providing a corrective emotional experience in adulthood.

It involves the therapist taking on a nurturing, supportive role while maintaining appropriate boundaries to promote healing and personal growth.

“A good internal voice is rather like – and just as important as – a genuinely decent judge, someone who can separate good from bad but will always be merciful, fair, accurate in understanding what’s going on, and interested in helping us deal with our problems”

Alain de Botton

Why is this more important with forensic clients?

- Patient in 'coercive' system
- Often referred to as 'offender' ... 'prisoner', deviant
- Inner critic, exclusion and rejection is often reinforced by society
- Treatment programs use terms as discharge, confrontation, cognitive disorders, denial, minimization

Therapy Relationship

- Healthy, stable, safe attachment
- Radical authenticity
- Empathic Attunement
- Focus on meeting core needs in relationships
- Cultivate safe **honesty without judgement**
- Strong emphasis on “**THIS MAKES SENSE**”
- HEALTHY LIMIT SETTING

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Therapy Relationship, in the 'here and now'

- Take every opportunity to build connection
- There is almost an opportunity in every session -- JUDGEMENT?
- Repeat healthy attachment
- Repair, Repair, Repair
- Natural response tempered by core formulation
- Self-disclosure but judicious
- Avoid detachment

Key Tips for building Rapport & Trust

- Expect resistance / disinterest / deception / attempts to manipulate **DON'T TAKE IT PERSONALLY !!**
- Trust is earned through **BEHAVIOUR not WORDS**
- **Do what you say you will** – be on time – be transparent in your communication and with who you are sharing information with !

Being honest when it is difficult: Phrases to remember...

1. "Are you interested in an alternative perspective?"
2. "Would you be open to exploring a different angle on this situation?"
3. "I have a thought that might provide a new insight; would you like to hear it?"
4. "Can we consider a different viewpoint together to see if it might shed some light?"
5. "I wonder how things might look if we approached it from another standpoint; what do you think?"
6. "Are you willing to contemplate a different interpretation of these events?"
7. "I'd like to explore a concept that might challenge our current thinking; what are your thoughts on that?"
8. "How about we consider some possibilities that haven't been addressed yet?"

You don't care about me!!

Healthy Adult 'Genuine' Responses

1. "I understand your doubts, and I recognize the pain you've lived through; my role is to guide you, but this journey is yours to take."
2. "Your skepticism is valid, and I see the suffering you've experienced; I'm here to support you while you navigate your own path to healing."
3. "I hear your concerns and empathize with your struggles; my commitment comes from understanding your pain."
4. "It's normal to feel uncertain; I acknowledge the challenges you've faced, and while I can help, the journey of change is up to you."
5. "I understand where you're coming from, and I see the hurt you've carried; I'm here to assist you, but ultimately, you are the one who must walk this path."

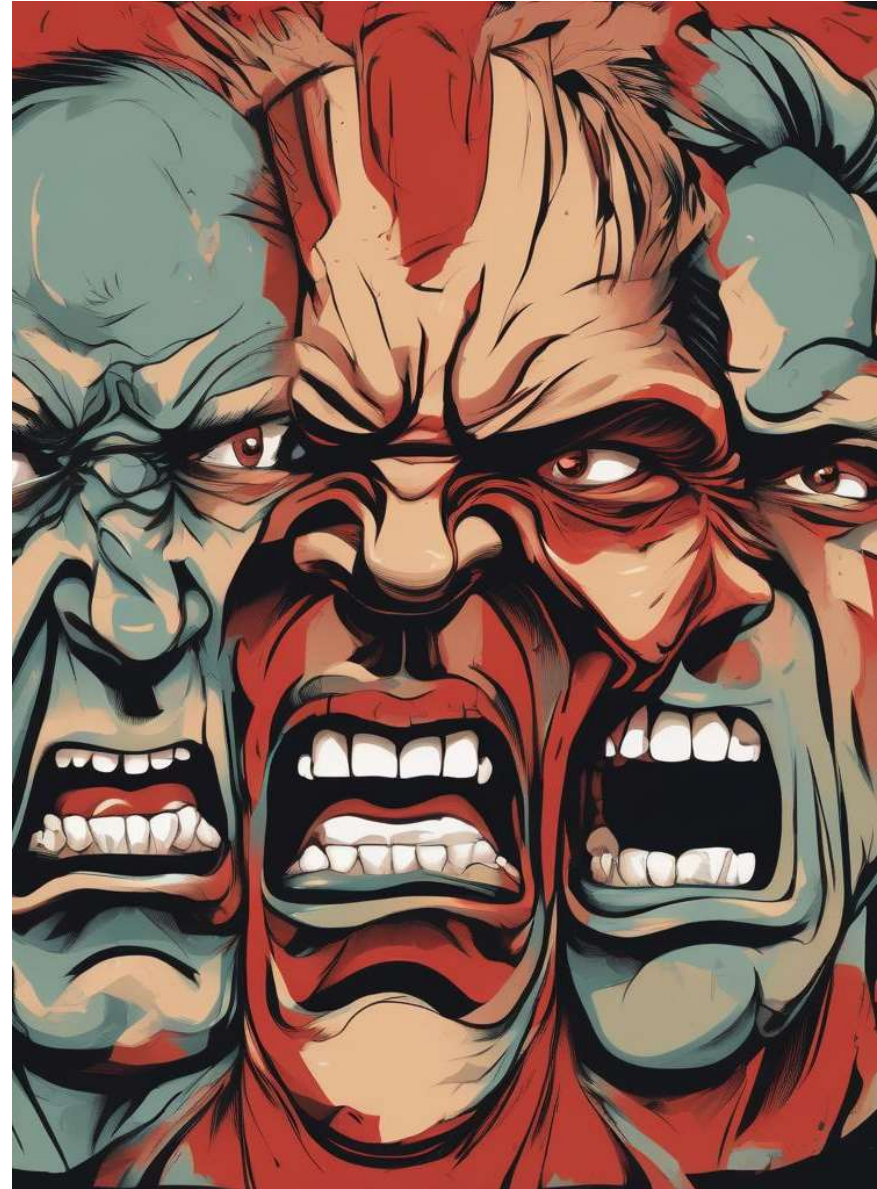
Phrases that can be used to start the process of healing a therapeutic ruptures..

1. "I apologize for my mistake; I understand that it may have led to feelings of unease, and I want to hear your thoughts on how we can regain trust in our work together."
2. "I'm sorry for my actions that may have caused you to feel mistrust; I want to acknowledge that and explore how we can move forward in a way that feels secure for you."
3. "Please accept my apology if I've made an error that has affected our relationship; it's important for me to understand your feelings and address any concerns you have."
4. "I apologize for my mistake and any discomfort it caused; I recognize that this may have contributed to your doubts, and I want to work on rebuilding our connection."
5. "I'm really sorry if my actions have created a rift between us; your feelings are important, and I want to ensure we can communicate openly about any issues that arise."

Difficult behaviours for us

- Lying / Manipulation
- Aggression
- Detachment
- Ambivalence to therapy and you
- Exposure to description of behaviours
- Confusing sexual behaviours
- Re-offending / Re-Lapse
- Our own religious, cultural norms
- Intense Anger
- Self harm / Violence

Forensic Schema Sessions "Live training"





Forensic Schema Sessions "Live training"

Key Problem:
When our modes
get triggered!!

When our Modes are active...

- When our modes are triggered it is difficult to work in the here and now with patients
- Bernstein & Navort (2020) identified three typical ways that this can occur:
 - Schema *Congruency*: Detached protector V Detached Protector
 - Schema *Complementarity*: Self Aggrandizer V Compliant Surrenderer
 - Schema '*Battle*': Coning Manipulator (?) V Paranoid Over-controller

Managing Schema Mode Triggers in Session

1. Self-Awareness & Schema Knowledge

- Understand your own triggers, schemas, and coping modes (avoidance, compliance, overcompensation).
- Tune into emotional/physical sensations to recognize when triggers occur.

2. Preparation Techniques

- Imagery: Visualize excluding your vulnerable child mode before entering the session.
- Connect to your Healthy Adult Mode: Reinforce your ability to engage from a strong, balanced perspective.

3. In-the-Moment Coping Strategies

- Use mindfulness and grounding exercises (e.g., breathing, feeling your feet) to re-center during sessions.
- Apply de-escalation strategies: Set boundaries, take breaks, or rephrase questions if needed.

Four Commonly used experiential techniques

- Bypassing a mode
- Empathic confrontation: Challenge patient about
- Limit setting
- Imagery



Empathic Confrontation

Definition:

- Actively challenge maladaptive beliefs and behaviors while maintaining a supportive framework.

Key Components:

- Validate patient feelings to create a safe space.
- Highlight discrepancies between thoughts, feelings, and behaviors.
- Promote awareness of harmful patterns while strengthening the therapeutic alliance.

Limit Setting

Definition:

- Establish clear boundaries regarding acceptable behavior and interactions in therapy.

Key Components:

- Communicate expectations directly and clearly to the patient.
- Manage behaviors from maladaptive schema modes (e.g., acting out).
- Foster a safe therapeutic environment that encourages accountability and healthy interaction.



Empathic Confrontation

Forensic Schema Sessions "Live training"

Steps to Empathic Confrontation

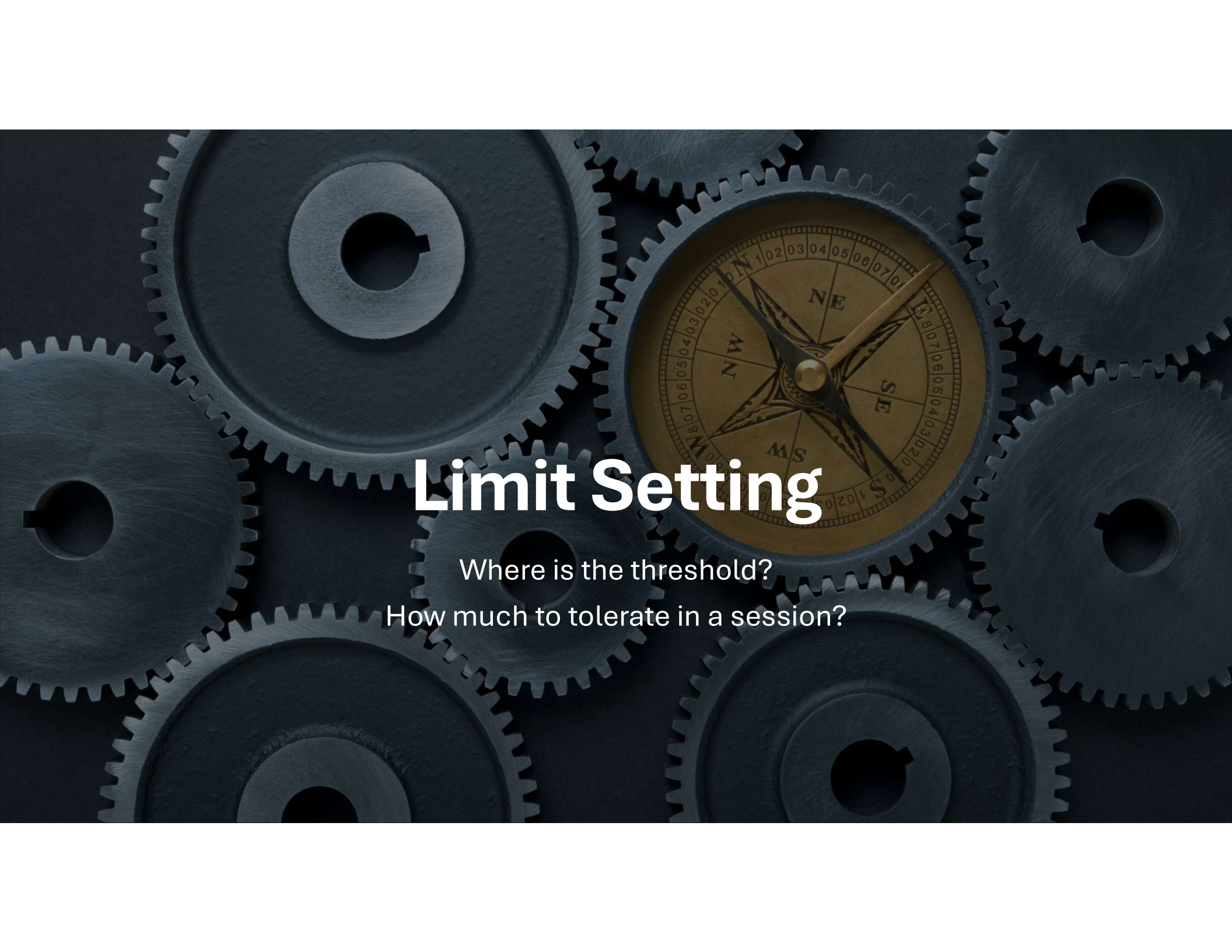
- 1. Reinforce connection with client**
e.g., Victor I care about that part of you that has suffered....
- 2. Name the maladaptive behaviour**
e.g., When this side of you comes out, this “I’m too good for everyone side”
- 3. Empathise and acknowledge the reason the behaviour developed and express concern that it does not get their needs met in an adaptive manner today**
e.g., I no longer want to help or be around you
- 4. Assist in conscious decision making**
e.g., I want us to work together to help you change this way of responding
- 5. Offer Correction – A behaviour that will get their needs met**
e.g., I have feelings too and would like to be respected here
- 6. Offer assistance in learning a new approach**
e.g., In this space we can start to practice different ways to communicate with each other

Farrell, Reiss & Shaw, 2014

Group Practice: Emapthic Confrontation

- Get into pairs of three's
- One therapist, one person plays Victor or another patient, the other observes; rotate where possible
- Follow the instructions of the handout provided.





Limit Setting

Where is the threshold?

How much to tolerate in a session?



6/07/2025

Better the Devil You Know – Oct 2023

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6/07/2025

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Practice Setting Limits



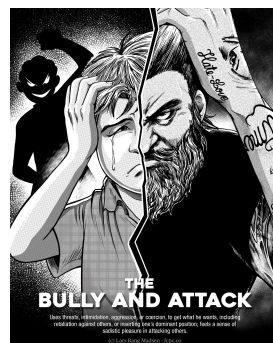
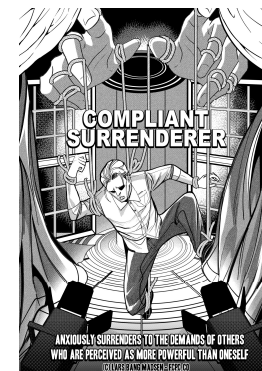
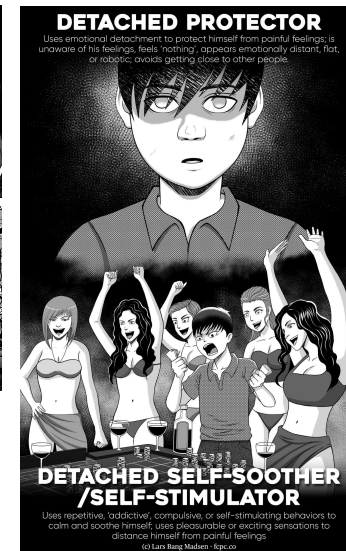
You are running late to your session with Victor, he is sitting waiting visibly annoyed and agitated, you sit down and apologize for being late and begins by yelling

“You know what I think about your being late? You don’t give a shit about me, you think you are so special you can go around being late whenever you feel like it, you’re just a cunt, now let me tell you how it is going to work around here from now on, you fucked up piece of shit”.

Overcompensating / Avoidant / Surrenderer Modes: The 'right' intervention (Bernstein & Navot, 2022)

Limit Setting & Empathic Confrontation

Not Limited Reparenting



Impulsive & Undisciplined Modes: The right intervention

(Bernstein & Navot, 2022)

Empathic
Confrontation
and/or Limit Setting

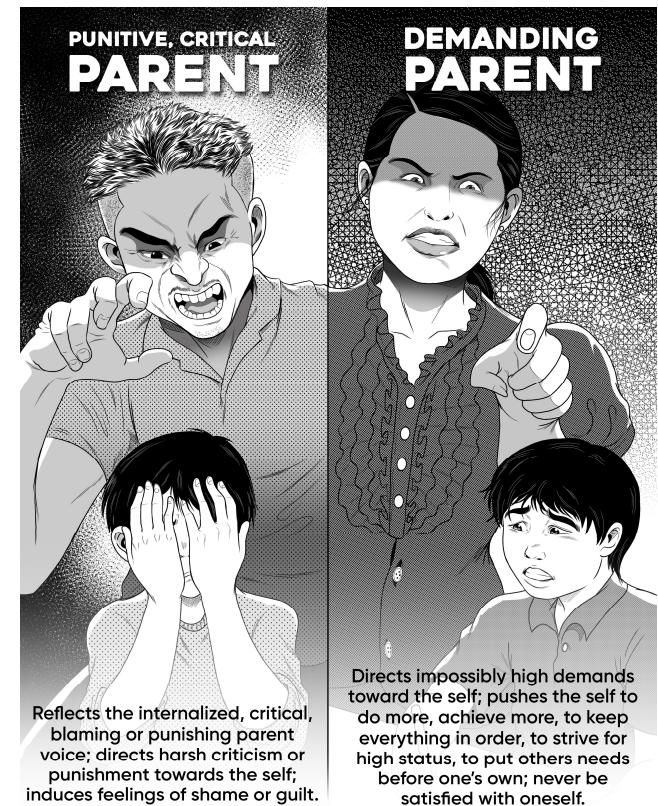
THE ANGRY CHILD

feels uncontrolled anger in response to
perceived mistreatment; acts like a child
throwing a temper tantrum



Critical-Punitive Modes (Bernstein & Navot, 2022)

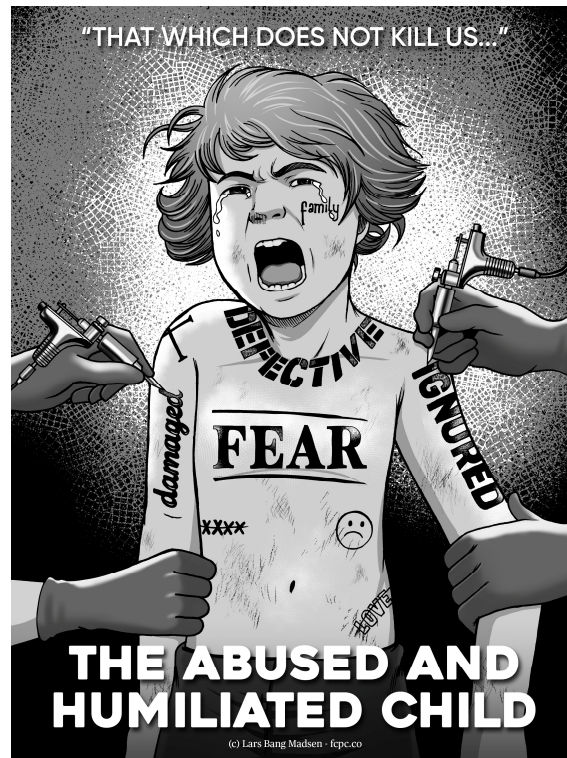
**Talk Back
Limit Setting**

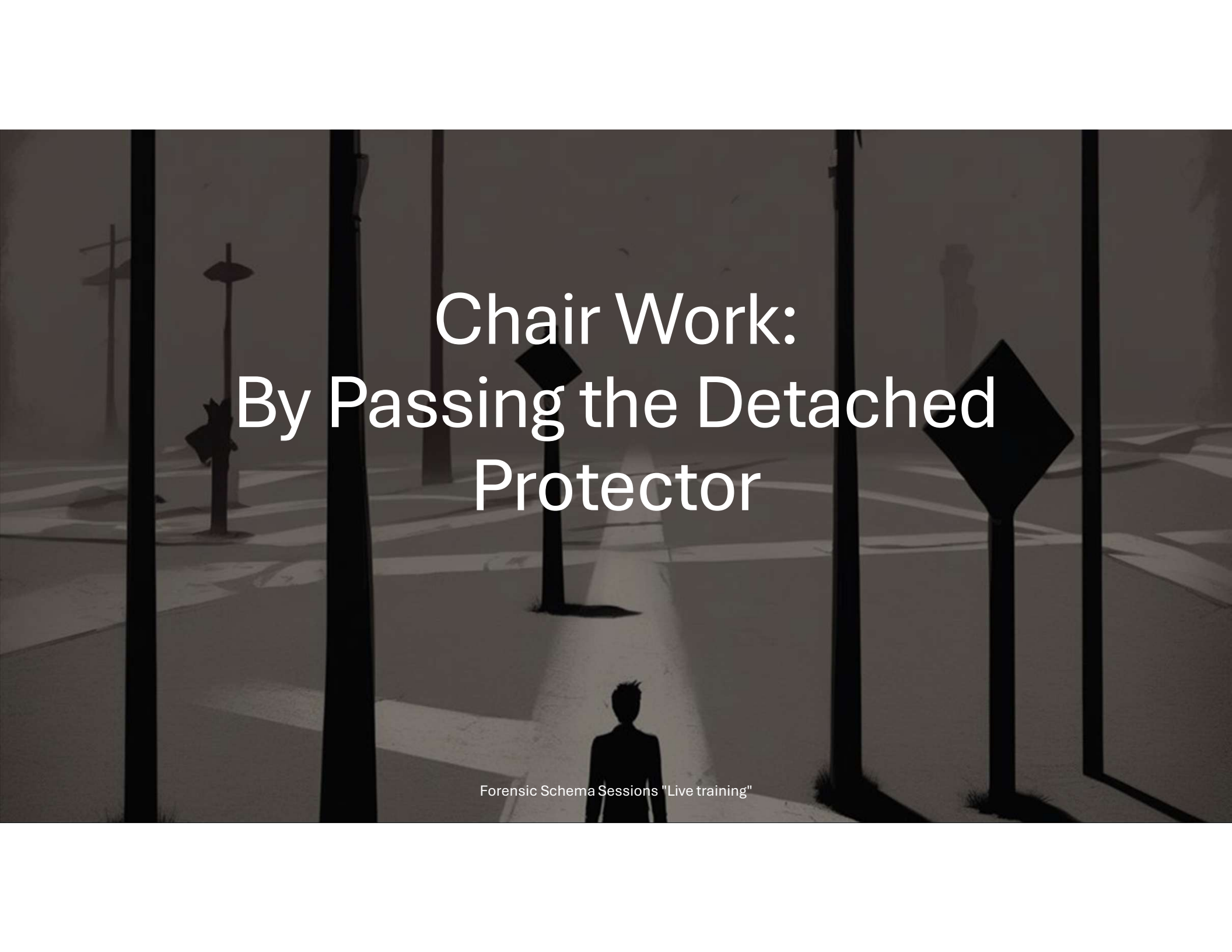


Vulnerable Child Modes: The right intervention

(Bernstein & Navot, 2022)

Limited Reparenting

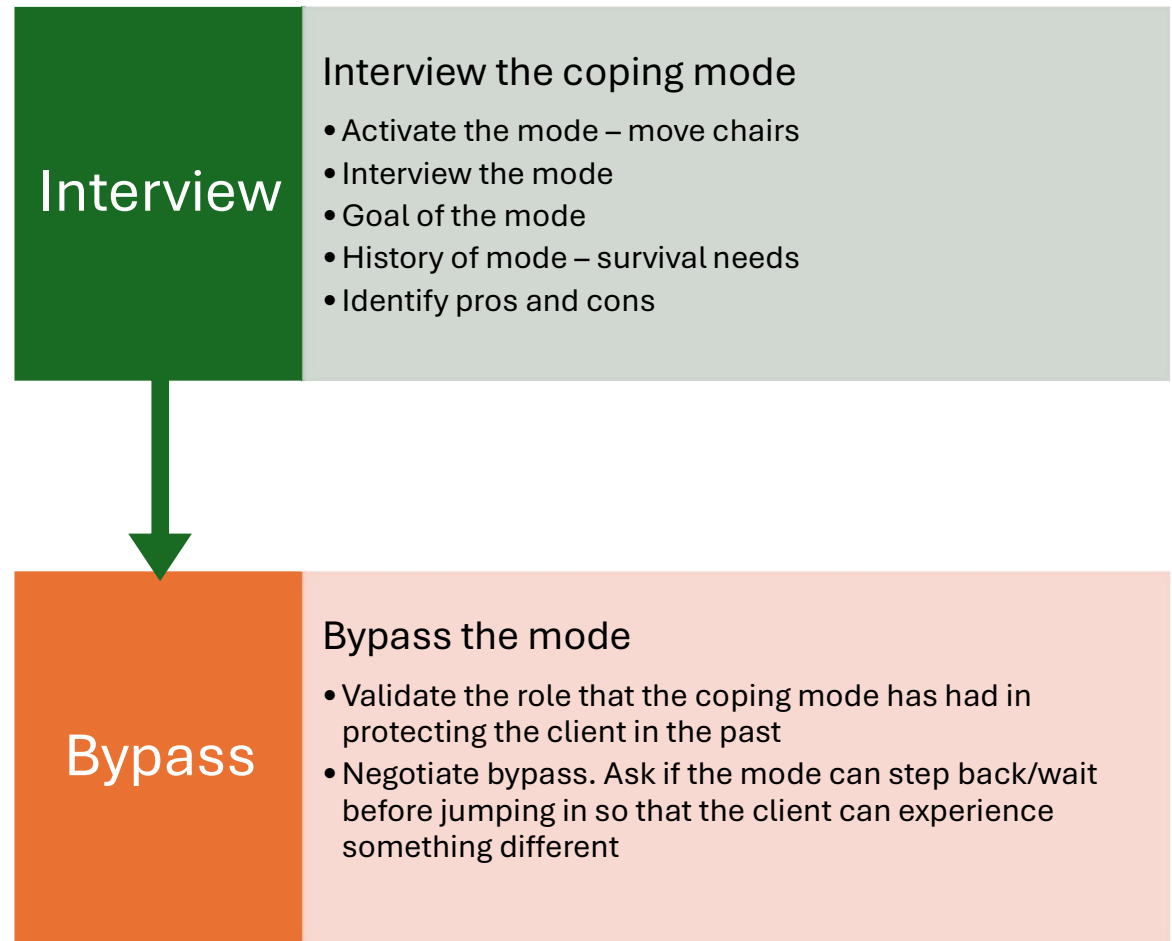




Chair Work: By Passing the Detached Protector

Forensic Schema Sessions "Live training"

Bypassing the coping mode



Group Practice: Bypassing the coping mode

- Get into pairs of three's
- One therapist, one person plays Victor or another patient, the other observes; rotate where possible
- Follow the instructions of the handout provided.

The background of the slide features a series of concentric circles in shades of gray, creating a hypnotic or tunnel-like effect. A single vertical line runs down the center of the image, dividing it into two equal halves. The text is overlaid on the right half of the image.

Imagery Rescripting

Dealing with the Abuser

Forensic Schema Sessions "Live training"

Imagery Rescripting

Definition:

- Modify distressing memories by revisiting and reshaping them in the imagination.

Key Components:

- Guide patients to visualize past events linked to maladaptive schemas.
- Encourage changes in outcomes, interactions, or emotional responses.
- Empower patients by integrating positive experiences into their memories, promoting healing.

Imagery Rescripting; Phase One Therapist Rescripts

1. Connect with the image
2. Connect with physiological and cognitive experience
3. Connect to needs
4. Bring Therapist into image
5. Attune to the Vulnerable Child Mode (VCM)
6. Meet the child's needs in the image and confront the antagonist
7. Continue the dialogue with the antagonist, until you win the exchange
8. Check in with the patient re: therapist meeting the need, standing up to antagonist
9. Finish providing safety and positive imagery
10. Debriefing the image and bring healthy adult mode into current life

Imagery re-scripting in forensics a ***dual process***

- When completing an imagery re-script there will often be an antagonist that you will be managing in the image.
- It is likely that the behaviours of the antagonist are the same or possibly similar to the maladaptive coping mode of the patient and linked to the offending sequence/behaviour
- When preparing the re-script you also need to formulate what is the mode management/treatment target for the patients maladaptive coping modes
- Imagery rescripting provides an opportunity to heal the VCM and re-educate/manage the maladaptive coping mode

Themes in rescripting

- Compassion and care
- Grief and Validation
- Empowerment
- Reattribution
- Safety

Possible Responses in Experiential work- Empowerment

Theme's based on schema Subjugation (feeling of being controlled, dominated, powerless)

- “ I am / we are running the show now.. not you”
- “I’m not going to let you do that....”
- “I’m not afraid of you...” “I can handle you fine”
- “I’m not going to let you dictate/ dominate”
- “You have no power over me”
- “I’m not going to be coerced by you”
- “I am done being submissive to you- it’s time for you to listen” (Client responds

Safety and Trust based themes

Mistrust/Abuse (lack of safety, lack of confidence, expects to be attacked)

- “I’m here to protect little X”
- “I’m not going to let you harm her” (to antagonist)
- “I’m not here to harm you little X” (to child)
- “She needed your protection, you let her down” (to care givers)
- She doesn’t deserve this...”
- “stop back off- “I’m stronger than you, I’m well-armed”
- “I’m not letting you touch him again”

Reattribution- Based Themes

Shame/Defectiveness

- “what is wrong with you... what you are doing/ saying is wrong ”
- “She doesn’t deserve this...”
- “I know I am right....” “you’re the problem”
- “what can a X year old do that deserves this....”
- “I’m not going to let you do this anymore”
- “you’re the one in wrong, who do you think you are”
- “What kind of person does that to a child”
- “I’m done with hearing X blame herself, you are the problem here”
- “I’m done blaming myself- you are the problem” (Adult re scripts)

Care and compassion based themes

Emotional Deprivation

- “You’re very important/ visible to me” (to child)
- “she/ he needs you to hear them, take them seriously....”
- “you need to show that you care about your kids”
- “She/ he needs you....”, “I know its hard for you, but all kids need attention, care etc)
- “Every child needs to feel like they matter.

Grief and Validation

- “its completely understandable that you feel that way”
- “Its makes sense that you want dad to be kinder to you”
- “it’s sad that people didn’t treat you that you deserved, i’m here and i care about you”

2nd stage- Client rescripts

1) a- current event with a floatback

1) childhood event- description

2) client comes in as the healthy adult- provides care, protection and “wins the exchange”

3) image is “rewound” to the point the adult client enters the image, and the client takes the perspective of the child

Healthy Adult: getting an image

- Pt needs to learn to visualize HA
- 2 Disclose about your own HA
- 3 Describe different aspects of HA
- 4 Explain these aspects as possible gateways to the HA in trigger situations
- 5 Imagery exercise in which pt visualizes HA identifying different aspects
- 6 Homework assignment to practice visualizing HA

Dealing with the Abuser

Therapist

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Group Practice: Imagery rescripting

- Get into pairs of three's
- One therapist, one person plays Victor or another patient, the other observes; rotate where possible
- Follow the instructions of the handout provided.

Recruiting the Healthy Adult (Chair Work)

Ensure that the intervention matches the mode

Modes	Intervention
Vulnerable modes (Abandoned, Abused, Humiliated, or Lonely Child)	Limited reparenting
Angry Child	1. Listen, 2. show empathy, and 3. switch from Angry Child to Healthy Adult or Vulnerable Child mode.
Impulsive Child or Undisciplined Child	Empathic confrontation, or limit setting
Critical or Demanding Parent	Talk back to the mode
Avoidant, Surrender, or Overcompensatory	Empathic confrontation, or limit setting

Creative Methods in Schema Therapy: Advances and Innovation in Clinical Practice, Chapter 12 Bridging the gap between forensic and general clinical practice. David Bernstein and Limor Navot pg 203-204.

Forensic ST / Randomised Control Study (RTC) Bernstein, et al. (2023)

- Evaluated the effectiveness of **ST compared to treatment-as-usual** in rehabilitating violent offenders with PDs
- Participants: 103 male offenders with Cluster B PDs (antisocial, narcissistic, borderline, paranoid).
- **Design:** RTC trial across 8 high-security forensic hospitals.
- **Duration:** 3 years.
- **Assessment:** Every 6 months on rehabilitation outcomes and PD symptoms.

Forensic ST / RTC Bernstein, et al. (2023)

Results:

- Both treatments led to moderate to large improvements.
- ST showed superiority to TAU in:
 - Rehabilitation outcomes (supervised and unsupervised leave)
 - Reduction of PD symptoms
- ST patients exhibited:
 - Faster progression through rehabilitation
 - More significant improvements in PD symptom scales

Conclusions:

- ST is effective in rehabilitating violent offenders with PDs, challenging the notion of their untreatability and supporting their reintegration into society.

Effectiveness of Schema Therapy for Individuals Who Committed Crimes: A Systematic Review

(Sousa, et al. 2024)

- Schema Therapy Shows Promise in Forensic Settings
- 15 studies included in the systematic review; mostly involving male participants in prison or forensic hospital settings.
- ST demonstrated beneficial effects on:
 - Early Maladaptive Schemas (EMSs)
 - Schema Modes
 - Personality symptoms
 - Risk factors for committing crimes (criminogenic needs)
 - Positive effects were observed both in prison and community settings.
- **Limitations:** Methodological limitations in many studies (small sample sizes, limited follow-up periods, heterogeneity in interventions) hindered the drawing of definitive conclusions.

Evidence base for Forensic Schema Therapy

Bernstein DP et al (2021). Schema therapy for violent PD offenders: a randomized clinical trial. **Psychological Medicine** 1–15.

Bernstein, D. P., Nijman, H. L., Karos, K., Keulen-de Vos, M., de Vogel, V., & Lucker, T. P. (2012). Schema therapy for forensic patients with personality disorders: Design and preliminary findings of a multicenter randomized clinical trial in the Netherlands. **International Journal of Forensic Mental Health**, 11(4), 312–324.

de Klerk, A., Keulen-de Vos, M., & Lobbestael, J. (2022). The effectiveness of schema therapy in offenders with intellectual disabilities: A case series design. **Journal of Intellectual & Developmental Disability**, 47(3), 218–226.

Doyle, M., Tarrier, N., Shaw, J., Dunn, G., & Dolan, M. (2016). Exploratory trial of schema-focussed therapy in a forensic personality disordered population. **The Journal of Forensic Psychiatry & Psychology**, 27(2), 232–247.

Wilson, N. J., Kilgour, G., & Polaschek, D. L. (2013). Treating high-risk rapists in a New Zealand intensive prison programme. **Psychology, Crime & Law**, 19, 5–6, 527–547.

Published single Case Studies:

Chakhssi, F., Kersten, T., de Ruiter, C., & Bernstein, D. P. (2014). **Treating the untreatable: A single case study of a psychopathic inpatient treated with schema therapy.** *Psychotherapy* (Chicago, Ill.), 51(3), 447–461.

Madsen, L.B. & Bernstein, D. P. (2023). Licht in einen Sexualmord bringen: Forensisch-schematherapeutische Fallkonzeptualisierung eines Kindermörders. In **Forensische Psychiatrie** (pp. 439 – 460), Springer.

Schema Modes, Offence Paralleling Behaviour (OPB) & Violence

- Herzog-Evans and Keulen-de Vos (2023) investigated the relationship between schema modes and OPB in a sample of 42 male forensic patients
- Retrospective assessments of schema modes during both criminal offenses and institutional violence incidents.

Schema Modes, Offence Paralleling Behaviour (OPB) & Violence

- While no significant differences were found in most schema modes between the two event types prior to their occurrence, analyses revealed distinct differences during the events.
- Specifically, during criminal offenses, there was a greater activation of **angry child, impulsive child, self-aggrandizing, bully/attack, conning/manipulation, and detached self-soother** modes compared to institutional violence incidents.

The "Frozen Child" Mode: Implications

- Lah & Saradjian (2016) proposed the **"Frozen Child" Mode** (n=1)
- A dissociative schema mode ("frozen child") where patients experience **emotional freezing as a protective mechanism**. This prevents access to other child modes (vulnerable child, angry child, etc.)
- The "frozen child" mode may explain why some individuals are considered **"untreatable"** using standard schema therapy techniques.

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The “Frozen Child”

- **Therapeutic Implications:** A strong therapeutic alliance based on emotional attunement. Connecting with the patient's emotional state, even when the patient is unable to fully access those emotions themselves. Repairing ruptures in the therapeutic relationship is crucial.
- **Effective Interventions:** Building secure attachment relationships is key. Limited re-parenting techniques and emotional communication, including the therapist's emotional disclosure.

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Forensic Schema Therapy - Key Points

- Forensic contexts have higher prevalence of ASPD, NPD, BPD & Psychopathy – consequently emotional states including aggression dishonesty, ruthlessness, etc.
- Adaptations – focus on modes, rolling with the challenges of poorly motivated patients, focus on offending / risk factors
- Forensic contexts present unique challenges for therapist, patient & the therapy
- Case conceptualization to include mode sequence of offending behavior, integrating forensic risk assessment, dynamic risk factors, and offence paralleling behaviors
- Bypass the mode to achieve access to the VCM/HAM
- Empathic confrontation to build insight and awareness into the maladaptive aspects of coping modes and access to the VCM/HAM
- Imagery to heal the VCM and manage modes
- Limit setting to ensure safety and build regulation skills (HAM)
- Ensure that the technique matches the mode presentation in the “here and now”





Consider ISST Accreditation

After completing Accredited Schema Training Course 1
& 2 consider:

Standard Accreditation:

20 Hours Supervision plus 1 Tape, 12 months min

Advanced Accreditation:

40 Hours Supervision plus 2 tapes 24 hours min

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A Hero's Journey

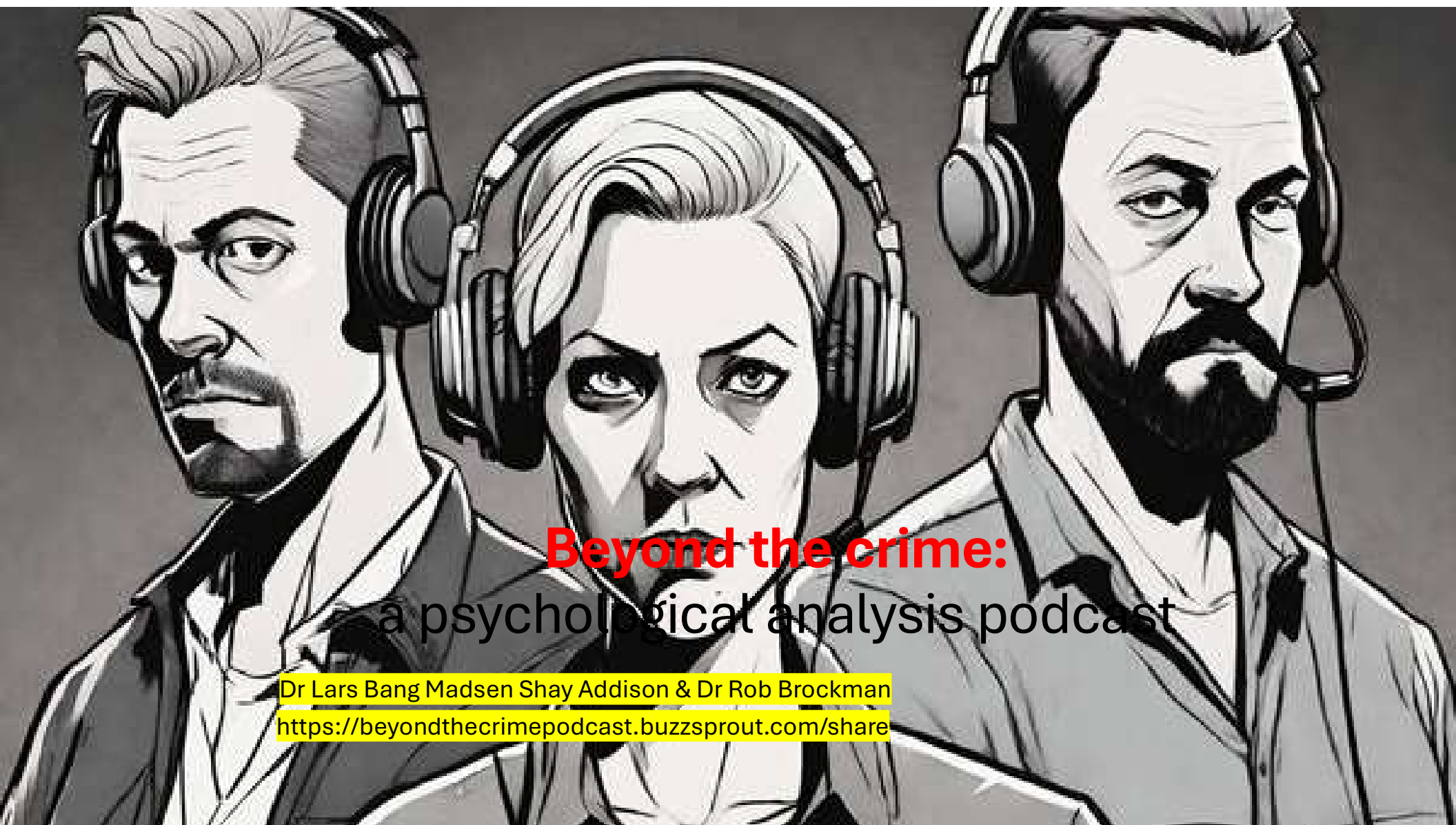
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