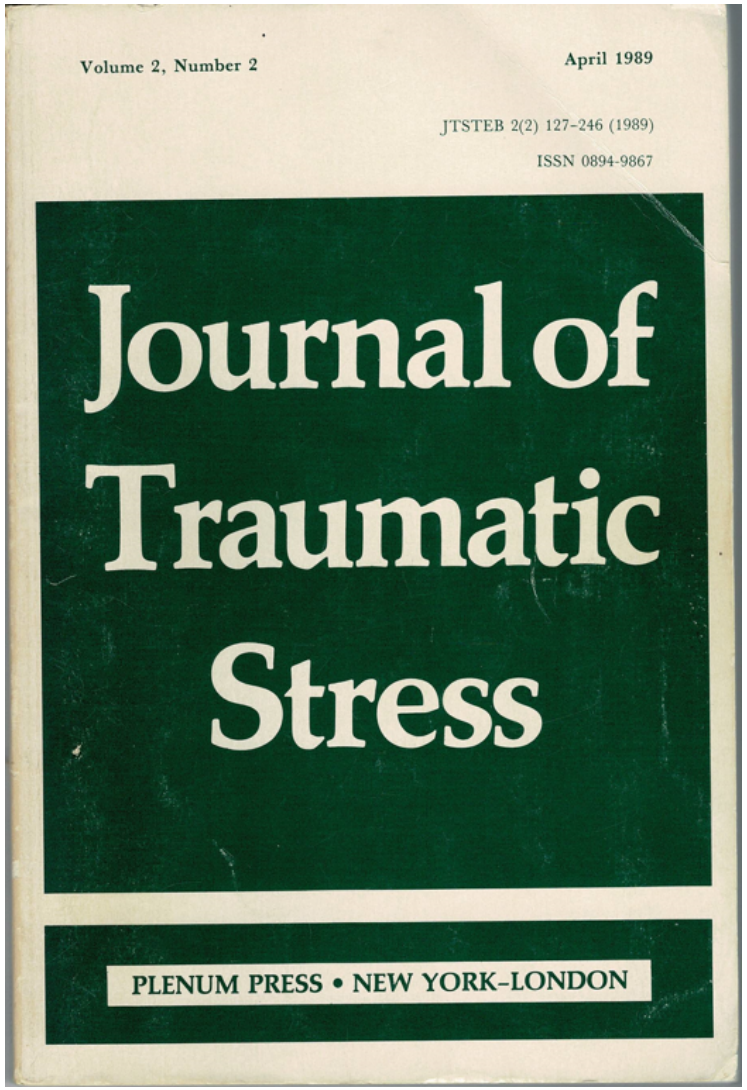
EMDR and Schema Therapy: The Whole is Greater than the Sum of the Parts

Graham Taylor

EMDRIA, EMDRAA Accredited Trainer, 1996+

Intl Soc Schema Therapy Accredited Trainer, 2008+

1989 was a good year for me …



As someone with a life long personal interest in trauma I had a personal subscription to this journal.

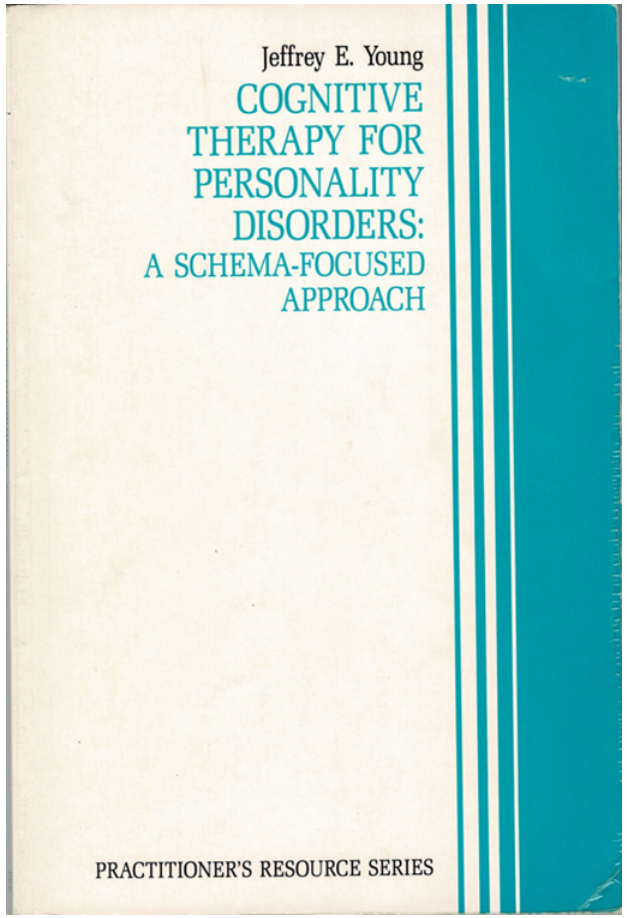
Shapiro's data was "too good to be true", so I had lots of questions.

In those days letters were written, posted and went by airmail. Back and forth …

And so began my training in EMDR. It changed my work for ever.
I started with carefully selected easy PTSD clients.

GPs noticed, and before most of my clients had trauma related presentations. And more complex ones too. Hmmm, that wasn't so easy.

A Really Good Year …



1989 – the first Cognitive Therapy Congress held at Oxford University, June 1989.

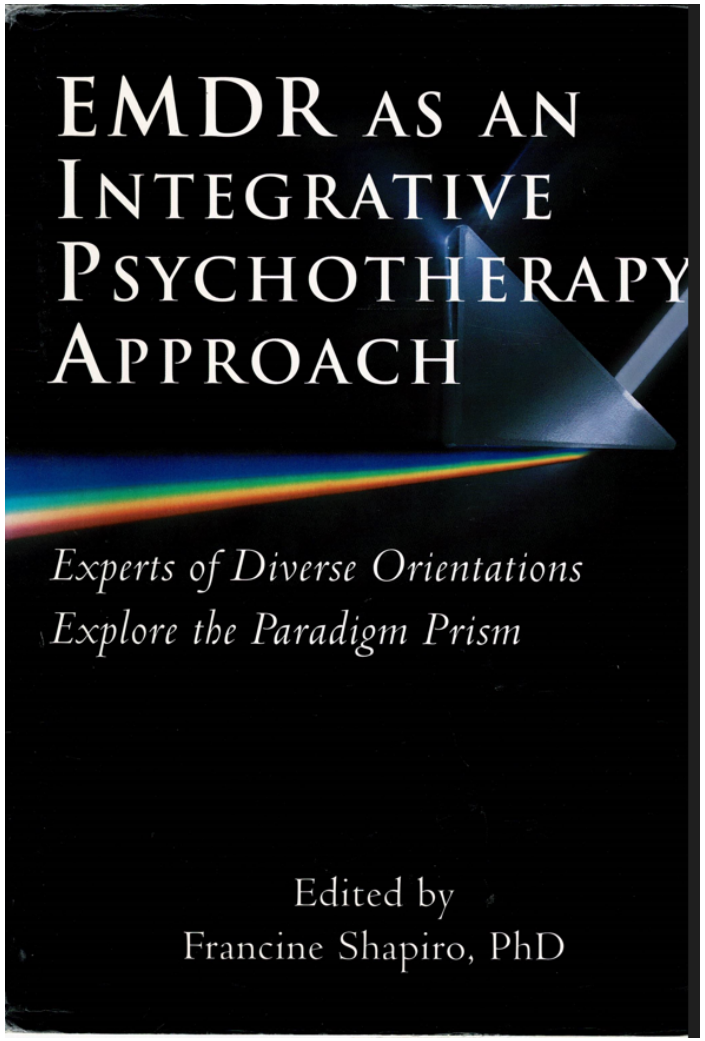
All the big names were there: Aron Beck, Albert Ellis, Martin Seligman, David Barlow, Donald Meichenbaum, Joseph Wolpe, Stanley Rachman and the emerging ones too.

Jeffrey Young, Director of Training at the Beck Institute in Philadelphia, presented a one day workshop on Schema Focused Therapy for Personality Disorder.

I'd struggled with clients with complex trauma / personality disorder issues, so I chose Young's session for the day.

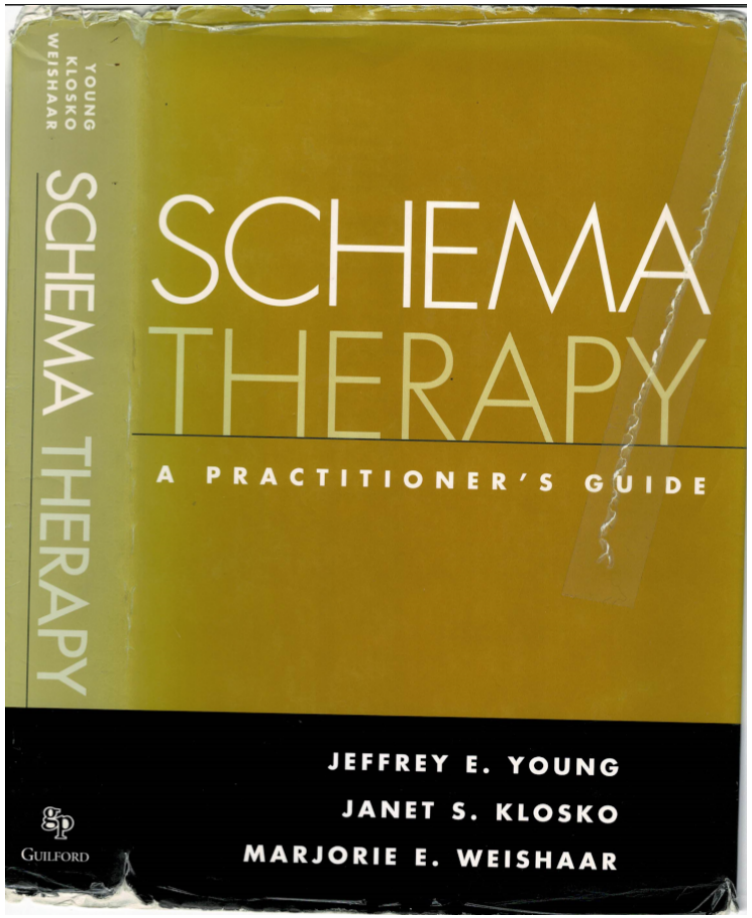
A day that changed me and my work forever.

And then there was this - 2002



Bessel van der Kolk – Somatic Experience
Dan Siegel – Interpersonal Neurobiology
Paul Wachtel – Psychanalysis
Des Poole – Cognitive Behaviour Therapy
Young, Zangwill & Behary – Schema Therapy
Arnold Lazarus – Multi-Modal Therapy
Steve Gilligan – Hypnosis
Les Greenberg – Experiential Psychotherapy
Laura Brown – Feminist Therapy
Florence Kaslow – Family Systems Therapy
John Norcross – Integration and EMDR

And in 2003, the foundational ST text



Absolutely no mention of EMDR.
Why might that be so?
Experiential change techniques focused on Imagery Rescripting and Chairwork dialogues.

Both can integrated in EMDR as resourcing and interweaves.

William Zangwill's story

- Intern at Jeffrey Young's Schema Therapy clinic in New York
  - William's problem with ST.
  - His solution was EMDR.
  - Introduced EMDR to Jeffrey Young, he took the training and began to use it.
- William facilitated for Shapiro in Australia, 1992 – 1996
- He arranged meeting of Shapiro & Young
  - How did that go?
- Shapiro avoided all substantive reference to ST in every edition of her text.
  - That's a great pity, IMO.

- Young & Zangwill did detailed presentations on integrating EMDR & ST at EMDRIA Conferences, 1995, 1996,1998. MP3 recordings are available.

The 2002 chapter” EMDR and Schema Therapy: The Whole may be Greater than the Sum of the Parts.

- EMDR and Schema Therapy “recognise the importance of all of the ways in which people process information – affectively, physiologically, through the senses, and cognitively.”
- “Combining aspects of each often yields better results than using either one alone”.

A brief recap of AIP (1)

- Memories are stored in associative memory networks and are the basis of perception, beliefs and behaviour.
- Trauma causes a disruption of normal adaptive information processing which results in unprocessed information being dysfunctionally held in memory networks.
- Adaptive information, resources, and memories are also stored in memory networks.
  - EMDRIA Curriculum, Summary of AIP.

AIP (2)

- “The AIP model views processing as an integration of the dysfunctionally stored memory within already existing networks containing adaptive information.”
- “Hence it emphasises the need for the existence of positive memory networks in order for processing to occur.”
- “Therefore, history taking involves assessing whether the positive networks exist and deliberately incorporating them if they do not.” (The latter strategy is called “resourcing”.)
  - From Solomon & Shapiro, 2008)

AIP (3) from Solomon & Shapiro (2008)

- “In the EMDR assessment phase, there are no specific attempts to change or reframe the client’s currently held belief. It is assumed that the belief will spontaneous shift during the course of processing.
- Nevertheless, from an AIP perspective, forging a preliminary associating between the negative cognitions with more adaptive information that contradicts the negative experience is believed to facilitate the subsequent processing by activating relevant adaptive networks.”
- Sounds like the cognitive stage of Schema Therapy. We’ll come back to this later.

A definition of Schema

- An Early Maladaptive Schema is
- a broad pervasive theme or pattern,
- comprised of memories, cognitions, emotions and bodily sensations,
- regarding oneself and one's relationship with others,
- developed during childhood or adolescence,
- elaborated throughout one's lifetime, and
- dysfunctional to a significant degree.
  - (Young, Klosko & Weishaar, 2003)

Schema theory (2)

- Maladaptive behaviours develop as *responses* to an EMS.
- Schema healing is the ultimate goal of schema therapy.
- Because a schema is a set of memories, emotions, bodily sensations, and cognitions, schema healing involves diminishing all of these; the intensity of the memory connected to the schema, the schema's emotional charge, strength of the body sensations and the maladaptive cognitions. *[EMDR does all these things.]*
- Schema healing also involves behaviour change, as patients learn to replace maladaptive coping styles with adaptive patterns of behaviour. *[EMDR does this too.]*

Comments

- EMS are self-defeating emotional and cognitive patterns that begin early in development and repeat throughout life. Hence the importance in assessing critical developmental tasks.
- Maladaptive behaviour is not part of the schema itself, but develops as a *response* to a schema. Hence the importance of assessing behaviour as both part of the presenting problem, and the goals of therapy.
- In ST behaviours are *driven* by schemas but are not part of schemas.
- Contrast this with Andrew Leeds Case Conceptualisation model that includes “action tendencies” as part of the memory network.

Comments

- What are commonly called Core Beliefs (Shapiro's Negative Cognitions) are the cognitive component of schema, but the schema is an associated network of memory, beliefs, emotion and body sensations.
- Shapiro placed no special emphasis on Core Beliefs. "Whilst persons beliefs are clinically useful distillations of experience, it is the affect feeding them that is the pivotal element in psychopathology" 1995.
- This contrasts with recommendations by de Jongh and Leeds that we cluster target memories in terms of common Core Beliefs.

Five contributions from ST for EMDR therapists

- A comprehensive model for assessing the impact of unmet childhood needs.
- A comprehensive and well researched model of schemas, which lead to identifiable Negative and Positive Beliefs (cognitions).
- Formal assessment tools which flow from this model.
- A comprehensive and well researched “parts of personality” model to work with so-called “avoidant” clients.
- Considerable emphasis on behaviour change.

First contribution of ST to EMDR

- Foundational developmental tasks underpin the development of schemas.
- Young focused on what he called “Early Maladaptive Schemas”
- The developmental foundation guides a detailed history taking to understand the client’s current presenting problems.
- Of course there are also Adaptive Schemas, which Young didn’t consider. These came much later.

Unmet Childhood Needs (1)

- CONNECTEDNESS: Secure attachment to others. Includes safety, stability, nurturance and acceptance.
  - Primary carers (parents) - classic attachment theory
  - Siblings – birth order effects
  - Extended family – cultural considerations
  - Friends
  - Peer group
  - Culture

  - Take home point: there is much more to Connectedness than Attachment.

Domain 1:Disconnection & Rejection

- The expectation that one's needs for security, safety, stability, nurturance, empathy, sharing of feelings, acceptance, and respect will not be met in a predictable manner.
- Typical family origin is detached, cold, rejecting, withholding, lonely, explosive, unpredictable, or abusive.
- Common schemas developing from this are emotional deprivation, abandonment / instability, mistrust / abuse, defectiveness / shame, social isolation / alienation

Schemas domains resulting from unmet childhood needs for Connectedness (1)

- Disconnection / Rejection
  - Abandonment / Instability
  - Mistrust / Abuse
  - Emotional Deprivation
  - Defectiveness / Shame
  - Social Isolation / Alienation

  - Typical Negative and Positive Beliefs – see handout

Exercise 1

- In the Chat Box list some questions you could ask to sample Connectedness – it's multiple levels. (Skip parental attachment - there are many existing resources to assess this.)
- These will be collated and sent to you later.
- You can take a copy of the responses in the Chat Box.

Schemas domains resulting from unmet childhood needs for Autonomy (2)

- Expectations about oneself and the world that interfere with a person's perceived ability to separate, survive, function independently, or perform successfully.

- Impaired Autonomy and Performance
  - Dependence / Incompetence
  - Vulnerability to Harm or Illness
  - Enmeshment / Undeveloped Self
  - Failure

Impaired Autonomy and Performance

- Expectations about oneself and the world that interfere with a person's perceived ability to separate, survive, function independently, or perform successfully.
  - Dependence / Incompetence
  - Vulnerability to Harm or Illness
  - Enmeshment / Underdeveloped Self
  - Failure

Exercise 2

- In the Chat Box list some questions you could ask to sample Autonomy
- These will be collated and sent to you later.
- You can take a copy of the responses in the Chat Box.

Schemas domains resulting from Impaired Limits (3)

- Deficiency in internal limits, responsibility others, or long-term goal orientation. Leads to difficulty in respecting the rights of others, cooperating with others, making commitments, or setting and meeting realistic personal goals.

- Impaired Limits
  - Entitlement / Grandiosity
  - Insufficient Self-Control / Self Discipline

Exercise 3

- In the Chat Box list some questions you could ask about Impaired Limits
- These will be collated and sent to you later.
- You can take a copy of the responses in the Chat Box.

Schemas resulting from Other-Directedness

- An excessive focus on the desires, feelings and responses of others, at the expense of one's own needs in order to gain love and approval, maintain one's sense of connection, or avoid retaliation.

- Subjugation
- Self-Sacrifice
- Approval Seeking / Recognition Seeking

- Exercise 4
- In the Chat Box list some questions you could ask about Other Directedness
- These will be collated and sent to you later.
- You can take a copy of the responses in the Chat Box.

Schemas domains resulting Over-Vigilance and Inhibition (5)

- Excessive emphasis on suppressing one's spontaneous feelings, impulses, and choices or meeting rigid, internalised rules and expectations about performance and ethical behaviour, often at the expense of happiness, self-expression, taxation, close relationships or health.
- Over-Vigilance and Inhibition Schemas
  - Negativity / Pessimism
  - Emotional Inhibition
  - Unrelenting Standards / Perfectionism
  - Punitiveness

Exercise 5

- In the Chat Box list some questions you could ask about Other Directedness / Inhibition
- These will be collated and sent to you later.
- You can take a copy of the responses in the Chat Box.

Second contribution of ST to EMDR

- ST provides a comprehensive model for understanding the dominant themes underlying a client's resenting problems
- Each schema has Negative and Positive Beliefs that are directly derived from the model.

The Schema Model

- Schema therapy has identified 18 schemas, grouped into five higher order domains.
- Any negative or limiting beliefs will be found within the model.
- ST's Core Beliefs go well beyond the triad of Responsibility, Safety and Control.
- This is a much more comprehensive model than the limited triad of responsibility / safety / choice proposed by Shapiro.
  - Shapiro (2018), in the section on Negative Cognitions, lists others such as "There is something wrong with me, I am not lovable, I am incompetent, I am different, I have to be perfect, etc.

A little more AIP theory

- “Adaptive information, resources, and memories are also stored in memory networks. Direct processing of the unprocessed information facilitates linkage to the adaptive memory networks.” EMDRIA Curriculum.
- [Processing] emphasises the need for the existence of positive memory networks in order for processing to occur. Therefore, history taking involves assessing whether the positive networks exist and deliberately incorporating them if they do not”. Solomon & Shapiro, 2008.

Positive Schema

- 14 Positive Schemas:
- Emotional Fulfilment
- Emotional Openness and spontaneity
- Empathic Consideration
- Self Compassion
- Social Belonging
- Realistic Expectations
- Healthy Self interest / self-care
- Healthy Self-reliance / competence
- Success
- Basic Health and Safety / Optimism
- Healthy Boundaries / Developed self
- Healthy Self Control / Self Discipline
- Self Directedness
- Stable attachment

Identifying / Strengthening Adaptive Networks

- Take a Positive Belief
- Find an experience that fits with that PB.
- Connect with the details of that experience.
- Connect emotions > body sensations
- Floatback to another memory
- Connect with details > emotions > body sensations.
- Repeat until you have a network of 5 memories with a common Positive Belief

Some data on this

- Memory of a negative event, NB, PB,
- Rate vividness, SUDs of memory, VoC of PB, VoC of NB
- Focus on PB and elicit 5 memories linked to this PB
  - I.e. connect with an adaptive memory network .
- Return to memory of negative event.
- Re-rate vividness, SUDs of memory, VoC of PB, VoC of NB

Processing effects occur just by strengthening a Positive Memory Network

Paired Samples T-Test

Measure 1		Measure 2	t	df	p	Cohen's d
Vivid-pre	-	Vivid-post	14.011	57	< .001	1.840
SUD-pre	-	SUD-post	14.385	57	< .001	1.889
NB-pre	-	NB-post	15.489	57	< .001	2.034
PB-pre	-	PB-post	−11.485	57	< .001	−1.508

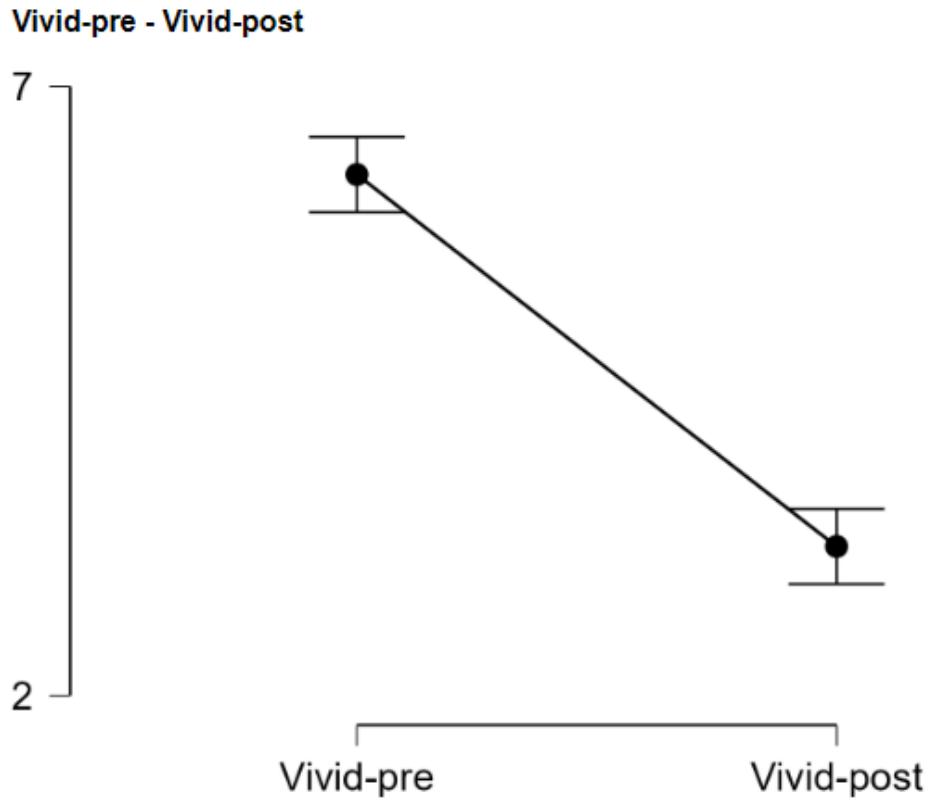
Note. Student's t-test.

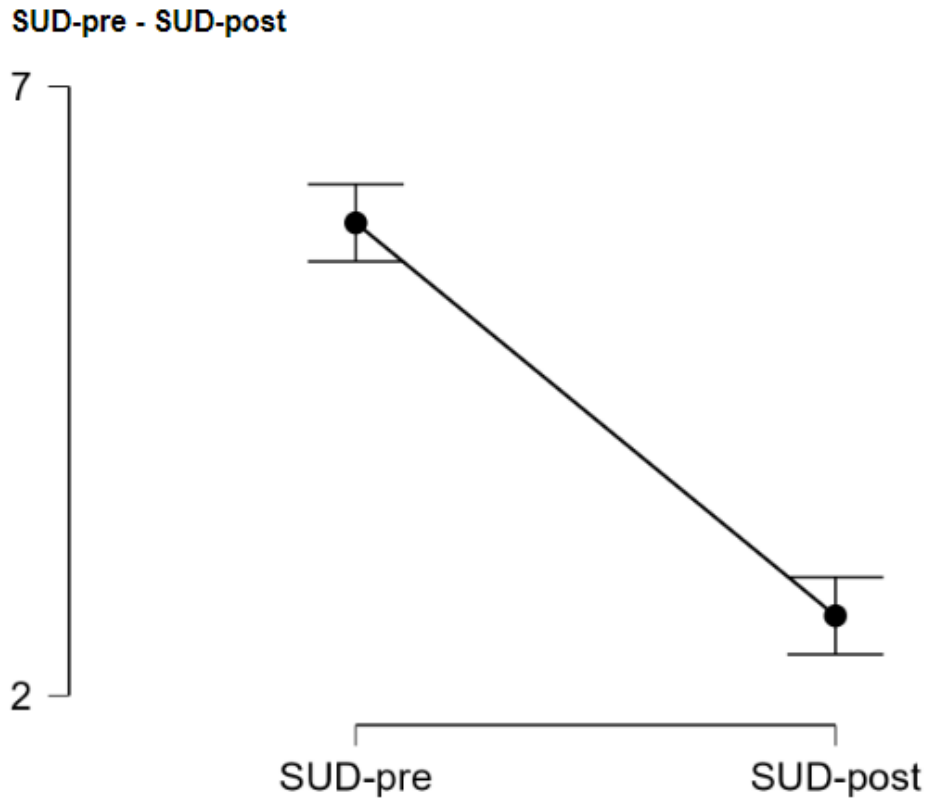
Descriptives ▼

Descriptives ▼

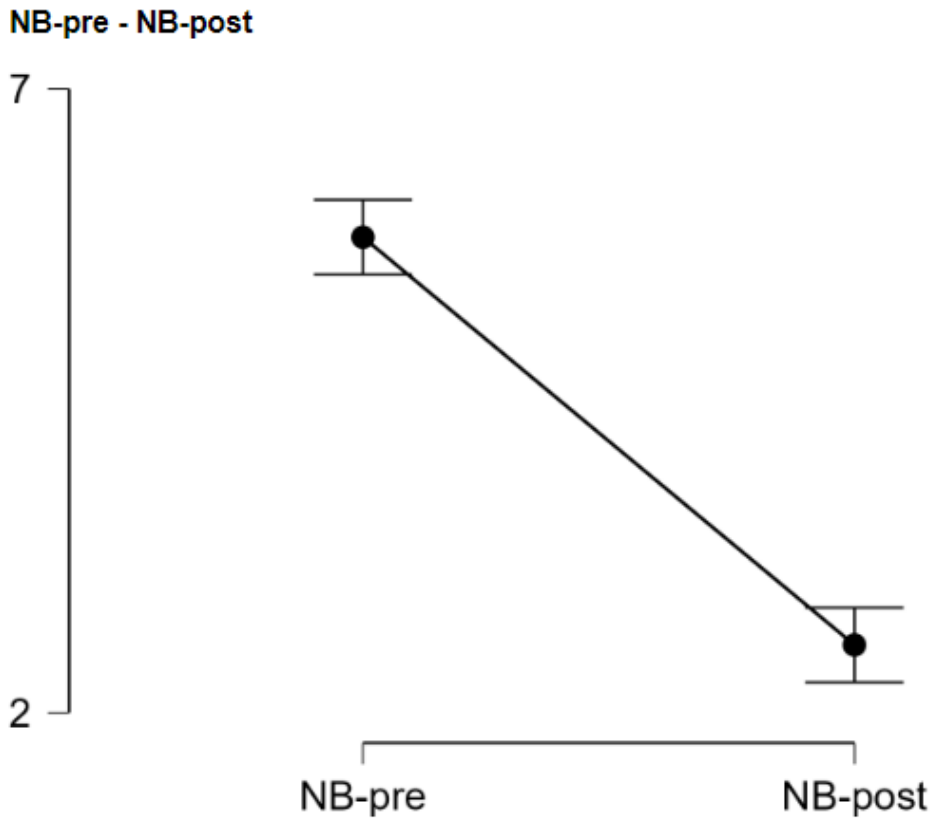
	N	Mean	SD	SE	Coefficient of variation
Vivid-pre	58	6.276	1.620	0.213	0.258
Vivid-post	58	3.224	1.545	0.203	0.479
SUD-pre	58	5.879	1.707	0.224	0.290
SUD-post	58	2.655	1.573	0.207	0.593
NB-pre	58	5.810	1.538	0.202	0.265
NB-post	58	2.543	1.265	0.166	0.497
PB-pre	58	3.000	1.389	0.182	0.463
PB-post	58	5.793	1.295	0.170	0.223

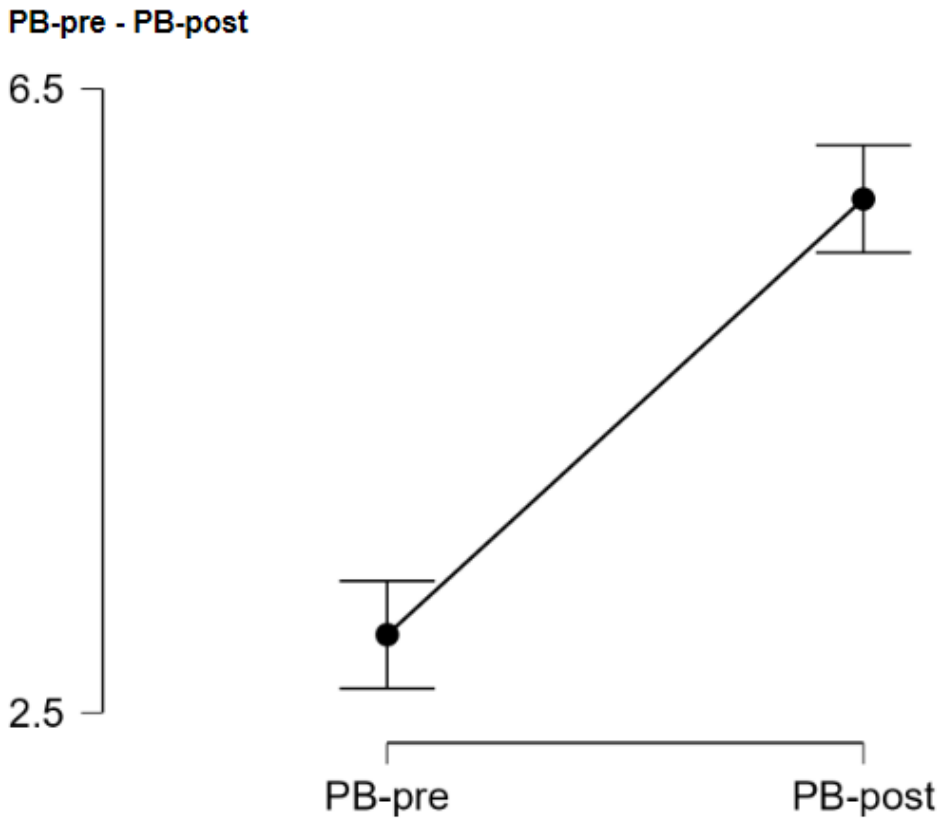
Results – Desensitisation Effects





Results – Reprocessing Effects





These results are predicted by AIP

- “the AIP model views processing as an integration of the dysfunctionally stored memory within already existing networks containing adaptive information. … Therefore, history taking involves assessing whether the positive networks exist, and deliberately incorporating them if they do not.” Solomon & Shapiro, 2008
- Also consistent with Memory Reconsolidation theory. Minimal activation of target memory + juxtaposition with incompatible information.
- This intervention will be taught in a later webinar.

Is this EMDR? Solomon & Shapiro, 2008.

- NO "In the EMDR assessment phase, there are no specific attempts to change or reframe the client's currently held belief. It is assumed that the belief will spontaneously shift during the course of subsequent processing.
- YES "Nevertheless, from an AIP perspective, forging a preliminary association between the negative cognition with more adaptive information that contradicts the negative experience is believed to facilitate the subsequent processing by activating relevant adaptive networks."

The take-home from this study

- Processing effects can occur just by strengthening a Positive Memory Network.
- No full activation of target memory, no BLS involved.
- Take home: including the assessment / strengthening of Positive Schema can enhance the client outcomes working with EMDR therapists.

Third contribution of ST to EMDR

- Schema assessments
  - Young Schema Questionnaire, short and long forms
  - Young Parenting Questionnaire, recently revised.
  - Young Avoidance Questionnaire
  - Young Compensation Questionnaire
  - Young Positive Schema Questionnaire
  - Positive Parenting Schema Questionnaire
  - Schema Mode Inventory

Schema Assessments

- Provide the therapist with a rich set of information which can guide the assessment of relevant memory networks, and the identification of specific target memories to form part of a treatment plan.
- Provide the therapist with information regarding the clients strengths, and areas of deficit.
- See Dropbox link for a library of resources.

Schema Assessments – lets take a look

- Young Schema Questionnaire - long and short versions, recent revision
  - Problems with YSQ – unequal number items for different schemas, large overlap in items, schemas are highly correlated – not orthogonal.
  - Unrelentingly negative, triggering for many clients –> over/under rating.
- Young Parenting Inventory – recent revision

- Young Positive Schema Questionnaire
- Positive Parenting Questionnaire
  - Better tolerated by clients
  - Identify strengths that can be utilised
  - Absence of strengths points to potential deficits

Fourth contribution of ST to EMDR

- A comprehensive “parts” model, which ST calls “modes”.
- This model has considerable empirical support.
- Therapies based on schema modes have demonstrated very significant positive outcomes, even with the more difficult Personality Disorder categories such as Borderline PD and Antisocial PD.

Schema Therapy's "Parts" model

- ST calls parts of personality "modes"
- They are states, not traits. We have Schemas as traits, in a given moment we are in a Mode.
- Modes (parts of self) vary on several dimensions
  - **Dissociated** **Integrated**
  - **Unacknowledged** **Acknowledged**
  - Maladaptive Adaptive
  - Rigid Flexible
  - Pure Blended

Schema Modes

- Healthy modes
  - Healthy Adult
  - Healthy Child
- Dysfunctional child modes
  - Lonely, Abandoned, Abused, Humiliated, Angry, Enraged, Obstinate
  - Impulsive
- Dysfunctional parent modes
  - Punitive parent
  - Demanding parent

Schema Modes (cont.)

- Dysfunctional coping modes
- Compliant surrender Engages in behaviour that directly maintains the self-defeating schema driven patterns
- Detached protector Uses emotional detachment strategies to escape or avoid distress arising from schema activation.
- Angry Protector Uses a “wall of anger” to protect themselves from others.
- Detached self-soother Detaches from emotions by engaging in activities that distract, soothe or stimulate.

Schema modes (cont.)

- Overcompensation modes
  - Self-aggrandiser
  - Attention seeker
  - Over controller
    - Perfectionistic
    - Paranoid
  - Bully and attack
  - Conning and manipulative
  - Predator

“Detached Protector” mode

- Clinical markers of DP mode.

Clinical Markers of Detached Protector mode

- The client pretends they are not feeling upset.
- The client pretends they are feeling and doing fine (to others, and themselves).
- They deny and minimise the effects of past trauma.
- The client responds to questions about their history with “I don’t remember”, “I don’t know”.
- Potentially relevant history is not revealed. (“defensively excluded”, Bowlby, 1980) If you don’t ask, you may not be told.
- Changes the subject, moves away from uncomfortable topics, talks around issues.
- Distracts the therapist with praise, flattery.
- Loss of eye contact – often points to shame.
- The client talks of painful experiences in a detached, intellectual manner.
- The client is overly-independent, self-reliant. They (need to) see themselves as independent, strong, normal. “Compulsive self-reliance.”

More clinical markers of DP mode

- The client becomes cynical or aloof.
- The client argues with the therapist.
- The client tends to devalue or dismiss intimacy, closeness, and vulnerability.
- The client's body posture is guarded, rigid, tense.
- Puts a positive spin or ending to a negative experience.
- Idealisation of a parent, but vague when asked for details. ("betrayal trauma", Freyd)
- Client hasn't done homework.
- Client comes late, or doesn't show up, or cancels.
- Use of black humour, making jokes about negative events.
- Asking to go to the toilet or get a glass of water during a session.
- Verbose speech, the client needs to keep talking, has trouble stopping.
- Wanting to focus on the "issue of the week" rather than something more substantive.

Still more clinical markers of DP mode

- Coming to session having self-soothed with medication, alcohol, drugs.
- Client feels numb, detached.
- Client starts session by talking about events unrelated to the work.
- Doing other things on a telehealth session. E.g. driving a car.
- Client reports feeling that they're not up to doing too much today.
- Client tells you they have another engagement straight after the session, when they would need some settling time after a processing session.
- Client tells you they need to leave early, so only want a short session.
- Client arrives for the session with young children who cannot be left unattended.
- Client calls at last moment to switch to a telehealth session.
- Client has a pattern of reporting debilitating symptoms just before the session, and postponing.

Responding to DP mode

- Empathically, caringly, call it out. ST calls this “empathic confrontation”.
  - Failure to do so reinforces DP mode.
- Validate it as a self-protective move.
- Explore the workability of that strategy.
- Process the barrier
  - Jim Knipe’s Level of Urge to Avoid
  - Two Handed Interweave
  - Resource figures as Interweaves
  - Chairwork / dialogues

Two handed Interweave

- Robyn Shapiro, EMDR Solutions, 2005
- It’s not actually an interweave.
- Two very useful resources:

https://emdrandbeyond.com/blog/2018/4/13/the-two-hand-interweave-clinical-intervention

http://emdr-podcast.com/episode-10-two-handed-interweave/

Fifth contribution of ST to EMDR

- An emphasis on the importance of behaviour change.
- Shapiro devotes only 4 pages of her text to this entire topic, with one key sentence.
  - “The treatment is not complete until there is a specific incorporation of an alternative be of hay fuel response pattern.” (2018, p 204.)
- Most EMDR therapists do not do EMDR on future targets as Shapiro described.
- In 33 years of EMDR, there is not a single published outcome study focusing on the “third prong” of EMDR.

What ST says about behaviour change

- “In the behavioural pattern breaking stage of treatment, patients attempt to replace the schema-driven patterns of behaviour with healthy coping styles. Behavioural pattern-breaking is the longest and, in some ways, the most crucial part of schema therapy. Without it, relapse is likely. Even if patients have insight into their Early Maladaptive Schemas, and even if they have done the cognitive and experiential work *[i.e. EMDR on past events and current triggers],* their schemas will reassert themselves if patients do not change their behavioural patterns. The progress they have made will erode, and eventually they will fall back under the sway of their schemas. For patients to achieve and maintain full gains, it is essential that they change their behavioural patterns”. Young, 2003.

ST on Behaviour

- Identifying dysfunctional behavioural patterns as part of the initial assessment.
- Identifying the behavioural goals of treatment is also part of the initial assessment, although these may be refined as treatment proceeds.
- ST uses a range of strategies. It will include skills building and coaching where the client lacks adaptive behavioural skills, e.g. assertiveness

Dysfunctional behavioural patterns

- Schema surrender The client lives out the schema, neither avoiding it or fighting it. They accepted the schema as true, and repeat schema driven behaviour patterns from childhood, repeating patterns that created the schema in the first place. (Freud, Repetition Compulsion)
- Schema avoidance Clients arrange their lives so that the schema is not activated. Thoughts and images are blocked, emotions are suppressed. Self soothing strategies may develop.
- Surrender / Avoidance might be 2 sides of the same coin.

Dysfunctional behavioural patterns (cont.)

- Schema compensation The client fights the schema by thinking, feeling, and behaving as if the opposite of the schema were true. Schema compensation may be a partially healthy attempt to fight back against the schema, but the compensation is often overdone.
- Schema driven patterns of behaviour are characteristically rigid and inflexible, what behaviour analysts call “Rule Governed Behaviour”.
- Breaking “Rules” inevitably evokes negative emotions: anxiety, shame or guilt.

Examples of Schema-driven behaviour

- From Young et al., 2003

EMDR on Future Targets

- First step. “the clinician should focus on the client’s ability to make new choices in future. This is done by identifying and processing anticipatory fears, as well as targeting a positive “future Template” that incorporates behaviour is appropriate for the future. This third prong of the EMDR therapy protocol includes adequate education, modelling and imagining in conjunction with EMDR targeting to allow the client to respond differently in the future”. Shapiro, 2018, p.203
- Note: Future Targets are imaginings of an a adaptive behavioural response.

Future Targets – First step

- “Close your eyes and imagine yourself responding in this new way in that situation”.
- “What emotions does that bring up for you now?”
- “How strong are these emotions now, on a scale of 0 = no distress, 10 = the highest distress possible”.
- “What thoughts are you having now about yourself responding in that way?”
- Process with standard EMDR, checking SUDS regularly until it stops reducing. 2 or 3 is generally an acceptable result.

Future Targets – Second step

- “the incorporation of a future template is an aspect of EMDR therapy that includes visualisation work similar to the kind done by some Olympic athletes during training. Imagining positive outcomes seems to assist the learning process”. Shapiro 2018, p.205
  - These statements are much weaker than the evidence permits.
  - All elite athletes utilise visualisation techniques in training. Without them they wouldn’t be a elite athletes.
  - Research on Imagery Rehearsal consistently shows two outcomes:
    - Increased self-efficacy (more confidence) re being able to execute the new behaviour
    - Increased level of skill upon initial execution of the new behaviour in real life.

The second step - Visualisation

- Shapiro assumes therapists are well versed in Imagery Rehearsal. She was much influenced by the early behaviour therapy tradition, e.g. Andrew Salter, Joseph Wolpe. Imagery techniques were largely abandoned when Behaviour Therapy became Cognitive Behaviour Therapy by the mid-1970s.
- Visualisation techniques are not described in her text.
- Shapiro describes the use of BLS with positive imagery. We know this leads to *reductions* in vividness of imagery and positive emotional charge . This is the opposite of what is desired.
- Less than 5% of people I train know how to do Imagery Rehearsal.

Example of future targets (1)

- 17 y.o., isolated in his bedroom of 3 years following public murder of his sister.
- His goal: “get my life back”. A very general goal
  - What would this look like? Get specific goals.
- Step 1 Create target > process emotional barrier to a tolerably low SUDs (2 or 3 is generally sufficient). WM effects.
- Step 2 Imagery Rehearsal – the PB becomes self-talk as he immerses himself in a “Mental Movie” of going to the local shopping centre.

Example of future Target (2)

- 28 y.o single woman, highly dissociated is her dominant state.
- Extreme levels of CSA from 5 – 13 y.o.
- 15 months of stabilisation & resourcing before processing CSA.
- 46 patterns of behaviour linked to NB “I’m not safe”.
- First future target: having lunch at hospital cafeteria, sitting away from the wall, with people behind her
- Fear > SUDs 8/10 Process to SUDs of 3
- “Storyboard” a Mental Movie of going to lunch, scene by scene.
- Script for Mental Movie

Future Targets Third step

- *In vivo* exposure with graded practice.
- This can be done with remote therapist assistance, e.g. Facetime.

So would your clients benefit from you knowing something about ST ?

- Is “the Whole Greater than the Sum of the Parts”?
- Or as Francine used to say at the end of her trainings, “the answer is in your hands.”

Acknowledgement: Thanks to Pam Pilkington for the list Negative & Positive Beliefs by Schema. And thanks to the trainees who have challenged me to clarify what it is I do for over 40 years. Hopefully this talk has helped explain that.