Schema Therapy
Case Conceptualization Clinical Example (Version 3.8)

You are advised to read the note on schema modes on page 24

Please type your responses into the boxes outlined next to each item.

Therapist's Name:	Melissa	**Date:**	17th December 2022
Number of sessions:	25	**Months since first session:**	8

*In completing this form you are advised to pay close attention to the instructions in each section as well as to the additional instructions included in the **Case Conceptualization Guide**, and to the way responses are set out in the **Case Conceptualization Clinical Example**.*

1. Client background information

Client's First Name/ID	Sandy	Age/DOB:	33
Current Relationship Status/Sexual Orientation/ Children (if any):	Sandy is heterosexual, single and has no children.		
Occupation and Position	Sandy owns a small business producing specialist savory starters which she supplies to restaurants. She employs 6 people.		
Highest Educational Level	Sandy completed high school, but has no tertiary qualification.		
Country of Birth/Religious Affiliation/Ethnic group	Sandy is Caucasian. She has no religious affiliation.		

2. Why is the client in therapy?

What are the primary factors motivating your client to come for treatment? What aspects of your client's life circumstances, significant events, symptoms/disorders, or problematic emotions/behaviors are contributing to their problems (e.g., health problems, relationship issues, angry outbursts, anorexia, substance abuse, work difficulties, stage of life)?

a. Initially	Sandy was first diagnosed with anorexia nervosa at the age of 17. After being hospitalized for this at the age of 23, she had four years of therapy and experienced some progress towards recovery from her eating disorder. She now has a normal, but low, BMI of 18.5 but she is constantly preoccupied with eating and trying to restrict and had been inducing vomiting daily. She came for therapy now because she wanted to be free of this constant preoccupation. She said that, if this were possible, she would like to "get my life back."

b. Currently	Sandy is currently experiencing anxiety and panic attacks associated with feeling overwhelmed with daily life. She is preoccupied with thoughts that her eating disorder is out of control and harming her. She recognizes that she is lonely but has difficulty making social connections. She seems to be motivated to overcome her eating disorder, address her anxiety and start making meaningful social connections with the goal, ultimately, of finding a partner and having a family. However, she has not made significant practical steps towards any of these goals.

3. General impressions of the client

Using everyday language, briefly describe how your client comes across in a global sense during sessions (e.g., reserved, hostile, eager to please, needy, articulate, unemotional). Note: this item does not include discussion of the therapy relationship or change strategies.

a. Initially	Sandy was intent on creating a positive impression and was compliant and eager to please. Initially she was motivated, attended sessions regularly, and followed through with homework tasks. However, she had difficulty staying with emotions, and did not understand the idea that emotions can be experienced in the body. Rather she thought of them as "in your head".
b. Currently	Sandy has become more motivated and engaged, although recently she has been canceling sessions at short notice and does not follow through with homework tasks. When this happens, she usually appears detached and indifferent. She also avoids talking about her eating disorder and distracts from it by talking about everyday activities. However, she has been able to engage in experiential exercises and has made progress in terms of being able to identify the emotion she is experiencing, although she still finds this difficult and uncomfortable.

4. Current diagnostic perspective on the client

Main Diagnoses: For each disorder, include the name and code using the diagnostic categories of either the ICD-11 or DSM-5-TR. Indicate here which system you are using: ICD-11

1.	6B81 Bulimia Nervosa	2.	6A71.6 Recurrent depressive disorder, currently in partial remission
3.	6B00 Generalized anxiety disorder	4.	6D10.1 Moderate personality disorder

5. Current level of functioning in major life areas

Rate your client's current functioning for each of the 5 life areas, and for Lifestyle self-care, in the tables below. See the **Case Conceptualization Guide** for detailed descriptions of each category, and the 6-point rating scale (1=*Not Functional/Very Low*, 6=*Very Good or Excellent Functioning*). In Column 3, briefly explain your rationale for each rating *in behavioral terms.* If your client's prior level of functioning was significantly different from the current level, please elaborate on it here.

5.1 Life areas		
Life area	**Rating**	**Explanation or Elaboration**
5.1.1 Occupational or educational performance	**4**	Sandy successfully runs a growing company. However, she uses work to avoid distressing feelings. Her work consumes most of her waking hours and she often works until late into the night. She also feels insecure about making everyday decisions such as how much stock to order and becomes anxious and seeks reassurance from employees about what to do.
5.1.2 Intimate, romantic, longer-term relationships	**1**	Sandy is lonely. In her teens, she had many casual sexual encounters, seeing this as the only way to find male affection as she did not believe that anyone could ever love and accept her. She had one heterosexual relationship lasting approximately 8 months. This ended when she was 21 after her boyfriend cheated on her while she was in hospital for treatment of her eating disorder. She has not had a romantic relationship for over 10 years.
5.1.3 Family relationships	**2**	Sandy's mother lives not far away and regularly drops in to Sandy's home on weekends, uninvited. Sometimes she comes to Sandy's workplace at lunch time. Sandy finds this irritating but is mostly unable assert herself; she anticipates being criticized for being uncaring and also feels sorry for her mother who is lonely, has no friends of her own and presents herself to Sandy as a victim in need of support. Her brother is married and lives in another province and they seldom have contact. She dislikes him because of his disdainful attitude towards her while she was growing up. Her younger sister has moved to another country where she is working, and they have little contact apart from polite greetings at Christmas and on birthdays.
5.1.4 Friendships and other social relationships	**2**	Sandy has very few meaningful connections and avoids going out with friends. She worries about being a nuisance and getting in people's way and believes that people will feel obliged to invite her out. She sometimes goes to workshops related to her restaurant work but has not made any longstanding social connections through this.
5.1.5 Solitary functioning and time alone	**2**	Sandy spends a lot of time alone but during such times she keeps herself busy or watches TV series to avoid feeling lonely and isolated. There is no enjoyment or comfort in her solitary time and, when she finishes work, she usually feels sad that she is alone and has no one to call. When she is alone, she also resorts to binge eating followed by self-induced vomiting.

5.2 Lifestyle self-care: Exercise, diet, sleep patterns etc.		
Lifestyle	**Rating**	**Explanation or Elaboration**
Lifestyle self-care	**2**	Sandy usually sleeps fairly well, though sometimes she cannot fall asleep as she worries about work related problems after working late. She does not take any form of exercise on a regular basis and her eating patterns are inconsistent, due to her eating disorder.

6. Major life problems

Identify three or more significant life problems (including symptoms and dysfunctional coping patterns) that, in your view, need to be understood and addressed in therapy if your client is to get relief from the distress they presented with. These problems may or may not be the ones that your client explicitly wants help with (as described in section 2).

6.1 Life Problem:	Bulimia nervosa: Preoccupation with food rules, and the appearance of her body with urges to binge and overcompensatory induction of vomiting.

Sandy is currently preoccupied with disliking herself with respect to her physical appearance and has constant fear of gaining more weight. She regularly restricts her eating and then has irresistible urges to snack and binge especially at home in the evenings. However, she sometimes eats high calorie foods such as cakes and chocolate while at work. Afterwards she induces vomiting. This preoccupation takes up a great deal of her time and the binging and induction of vomiting are followed by intense self-critical and self-punitive thinking.

6.2 Life Problem:	Social isolation and loneliness

Sandy feels lonely and would like to have friends and settle down with a husband and have a family of her own. However, she avoids going out and meeting people because she believes that no one could truly love her and that friends will feel obliged to invite her. She is also afraid of getting close to anyone as this evokes fears of abandonment and at times when she has allowed this to happen she has felt dropped and a sense that "they will always leave you." Sandy's main relationship is with her mother whom she sees often, especially at weekends. She never discloses any of her own experiences or aspects of her life with others because she believes they will judge her or find her boring or a nuisance. However, she rationalizes about why she does not socialize. However, this avoidance reinforces her sense of isolation and loneliness which, in turn, cause her to be depressed.

6.3 Life Problem:	Chronic anxiety related to worrying and rumination

Sandy constantly worries not only about her appearance and weight but also about decisions to be made at work. This is mixed with rumination on themes such as being unlovable, people not being interested in her and images of growing old alone. This alternates with fantasies of finding a husband and having a family. This activity maintains her constant anxiety and low mood and contributes to further avoidance of people. She worries about any decisions she has to make in her work setting and ruminates over minor mistakes. Consequently, she constantly asks for reassurance about her decisions at work.

6.4 Other Life Problems:	Inability to be assertive in relationships

Sandy tends to be very compliant and focused on pleasing others and keeping them happy. This is regularly played out with her mother who lives nearby and who imposes herself on her both at home and at work. Sandy often stays at work late, to avoid having to spend a lot of time with her mother (although the working late is also a way of keeping busy to avoid her feelings of loneliness). At work her mother often arrives close to lunch time and sits in Sandy's office wanting to chat, which is mostly very inconvenient for Sandy. Sandy is completely unable to speak to her mother, make her needs known to her and set limits to this behavior.

7. Childhood and adolescent origins of current problems

7.1 General description of early history

Summarize the important aspects of your client's childhood and adolescence that contributed to their current life problems and to the development of the maladaptive schemas and modes that you will be describing later. Include any major problematic / adverse / toxic experiences or life circumstances. See the **Case Conceptualization Guide** for more detailed guidance.

Sandy is the second of three children. Her parents got married because her mother fell pregnant with her brother. Her mother felt deep shame about this. Her father was an extroverted but unaffectionate man who was often away traveling for business. Before she fell pregnant. Sandy's mother was a model who was very conscious of her looks and weight. However, she believed she was not good enough for her husband, and, once married, was subjugated to him, and did not have an independent life. She was self-centered, often depressed and caught in a victim role. She failed to provide nurturance or affection and was unable to attune to her children's needs. She was often stressed and exasperated by the demands made on her by the children. When Sandy was 2, this intensified after the birth of her younger sister. Sandy learned that her needs were not important: if she asked for a hug, her mother accused her of being "that demanding child again" and complained "that there was something wrong with her." Her mother was critical and shaming in other ways, making derogatory comments about Sandy's appearance and telling her she needed to wear dresses and look more like a girl, implying that there was something wrong with her. Sandy felt neglected and hurt by her father who showed an obvious preference for her brother. She felt abandoned by him and when recalling one of these memories, reported a painful sense of "they always leave you," as well as anger. Despite this, she maintained an idealized image of him as a kind good person.

Sandy was a rather chubby child, and her mother and brother mocked her for this. At school, too, her peers teased her mercilessly about her weight and this intensified at the beginning of high school. Sandy had one close school friend who, like her, was excluded by the other girls. The peer group mocked them both for being too serious and studious and for still playing with dolls and other games that they saw as childish, while they were getting interested in boys and having parties. These criticisms compounded Sandy's social isolation and her sense that she could not trust anyone to be kind to her and not try to harm her. They heightened her perception of herself as not being valuable or important to anyone and her sense of being incompetent to make decisions for herself. She coped by striving to do things perfectly.

When Sandy was 9, her father collapsed and died from a heart attack while she was with him in the kitchen. She felt abandoned by him and blamed herself for not preventing his death. Her mother took over the running of her father's company and became even more stressed and irritable. Anxious that her mother would die too, and seeing her now as a helpless victim, Sandy determined to help her as much as possible, and assumed a rescuing role, doing all she could to make her happy. Her mother became dependent on alcohol and neglected the children even more, compounding Sandy's sense of being a burden and a nuisance.

Later, in high school, Sandy became rebellious and, to gain acceptance with other rebellious peers, she was influenced into smoking and drinking. From the age of 15, to attract attention from boys, she became sexually promiscuous. However, her friends were more popular with boys than she was. She attributed this to her being overweight (BMI 25.6) and started restricting food in order to lose weight. By the age of 17, she met criteria for anorexia nervosa, with a BMI of 17. At this weight, she felt more confident and

more accepted by her peers, which reinforced the restricting behavior. By the age of 21, her BMI had dropped to 14.5 and she had to be hospitalized after a crisis precipitated by her boyfriend threatening to break up with her. This led to some positive changes as, over the next few years, with the help of a therapist, she was able to achieve and maintain a normal weight. However, her boyfriend cheated on her and ended the relationship, and her sense of defectiveness did not change. "I can't be good enough for anybody," she said. "I'm trying to think of something I like about myself. But there's nothing. I can give you all the negatives. I wouldn't want to hang out with me."

7.2 Evaluation of unmet core needs

Below is a list of the core needs of a child with respect to their relationship with their parents or other caregivers, particularly in the first years of life. For each one, evaluate the extent to which the need was met, based on your description of the history in section 7.1, using this scale:

X = not enough information to evaluate
0 = hardly at all: extreme failure to meet this need
1 = to a very limited extent
3 = to a moderate extent
5 = to a very large extent.

Put your rating in the space provided, then:

a. Briefly refer to the origins of the unmet need, based on information from the life history and other sources - see the **Case Conceptualization Guide for** suggestions about this. Where appropriate refer to different life phases: for example, infancy and early childhood, middle childhood, adolescence.

b. List the Early Maladaptive Schema(s) to which the unmet need contributed. **Do not give any further explanation here** as you will be asked for more information about specific schemas in section 8.

7.2.1 Need for connection (nurturance, acceptance, unconditional love)	**Rating**	**2**
(a) Origin(s)	At no stage in her life has Sandy felt securely loved. Her mother was self-absorbed, emotionally disconnected, inattentive and often actively dismissive of Sandy's needs for closeness, affection, reassurance and comforting. She was sometimes significantly depressed and almost always self-absorbed. Sandy's father was absent because of work to the point she felt regularly abandoned by him and when he was home, he was not particularly affectionate and gave more attention to her brother.	
(b) Schemas	Emotional Deprivation, Defectiveness/Shame, Abandonment/Instability, Social Isolation, Subjugation, Self-Sacrifice	

7.2.2 Need for support and guidance in expressing and articulating needs and emotions and learning healthy socialization	**Rating**	**2**
(a) Origin(s)	Her mother was irritable and dismissive of Sandy if she expressed any need or showed emotion. For example, when she asked her mother for a hug, her mother became exasperated and told her that there was something wrong with her. Her father ignored her and spent most of his time with her brother when he was home. Consequently, Sandy learned to suppress her emotions and needs and became socially anxious and avoidant.	
(b) Schemas	Emotional Deprivation, Defectiveness/Shame, Emotional Inhibition, Subjugation.	

7.2.3 Need for safety, dependability, fairness, consistency, and predictability	Rating	1
(a) Origin(s)	Sandy's mother was often emotionally volatile, unpredictable and emotionally unstable. Her mother's dependence on alcohol after her husband's sudden death when Sandy was 9 added to her unpredictability and she presented herself as a victim who needed to be rescued leaving her even less able to be there for Sandy in any consistent way. Sandy's brother repeatedly behaved abusively towards her and neither her mother nor father took any steps to protect her from this. At school, Sandy was bullied and felt unprotected by both her family and school authorities.	
(b) Schemas	Subjugation, Dependence/Incompetence, Defectiveness/Shame, Mistrust/Abuse,	

7.2.4 Need for compassionate, firm and appropriate guidance and limit-setting to support the learning of realistic limits and self-control	Rating	2
(a) Origin(s)	Sandy did not receive appropriate guidance. There was no time spent by either parent in getting to know her goals and dreams, let alone helping her to pursue them in an authentic and balanced way. As a teenager however, she became rebellious and sexually promiscuous, in ways that put her at risk at times. Neither parent was attuned enough to pick up on this, and, to the extent they did, neither was capable of initiating and following through on appropriate steps to keep her safe and help her with self-control.	
(b) Schemas	Emotional Deprivation, Subjugation, Emotional Inhibition	

7.2.5 Need for support and encouragement of play, emotional openness and spontaneity	Rating	1
(a) Origin(s)	Neither mother nor father encouraged her in any spontaneity or playfulness or having fun. Instead, they regularly criticized her and put her down. Consequently, she suppressed her spontaneity, and learned to turn her attention away from her experience of her own spontaneous emotions and needs.	
(b) Schemas	Defectiveness/Shame, Subjugation, Emotional Inhibition	

7.2.6 Need for affirmation of capability and development of competence (Autonomy support):	Rating	1
(a) Origin(s)	Neither parent gave Sandy any sense that they believed in her and her capacity to develop as a capable and successful individual. She overheard her mother telling her friends that Sandy was not good at schoolwork. Neither parent offered her guidance or support in becoming more confident and assertive. Her mother's repeated criticisms and comments about how she was falling short rather than any support for identifying and helping her pursue her own goals and effort to identify what she was good at or doing well, undermined Sandy's sense of competence and confidence in herself. After her father's death her mother became even more self-absorbed and less available to focus on this aspect of Sandy's life.	
(b) Schemas	Emotional Deprivation, Dependence/Incompetence, Defectiveness/Shame, Social Isolation/Alienation, Failure, Mistrust/Abuse, Subjugation, Unrelenting Standards/Hypercritialness, Negativity/Pessimism	

7.2.7 Need for respect in developing autonomy, e.g. being afforded privacy and the freedom to learn to do things one's own way (Autonomy Granting):	Rating	2

(a) Origin(s)	Sandy had almost no sense of freedom and control over her own life. She was expected to look a certain way, to wear dresses, "look more like a girl", to have a slim figure, and, especially, to put her mother's needs ahead of her own. Her mother often made derogatory comments about how she looked. She was mocked for appearing chubby both at home and at school. She was not respected for taking her school work seriously, being studious, and playing with dolls and the games she was interested in.
(b) Schemas	Emotional Deprivation, Defectiveness/Shame, Dependence/Incompetence, Subjugation, Self-Sacrifice, Approval/Recognition-Seeking.

7.2.8 Need for support and guidance in developing a sense of intrinsic worth that is not dependent on being better than others	Rating	1

(a) Origin(s)	Neither parent acted as if they were attuned to her or valued her or gave her any explicit indication that she was valuable in her own right. Both parents and her brother let her know directly and indirectly that they were superior to her in a range of different ways. Her mother regularly shamed her about her weight and appearance and learned from her mother, brother, father and peer group that if she could achieve a certain weight and figure, she would then be worthy of love. Her attempts to find love, through school work or in her personal life, became exclusively performance based. She became convinced that remaining true to herself would lead to abandonment and loneliness.
(b) Schemas	Defectiveness/Shame, Dependence/Incompetence, Emotional Inhibition, Unrelenting Standards/Hypercriticalness

7.2.9 Need for a parent/caregiver who is experienced as confident and competent (a healthy role model)	Rating	2

(a) Origin(s)	Whatever sense Sandy might have had that her father was providing some security for the family in the world ended with his sudden death. Before that her mother's unpredictability and episodes of depression gave Sandy no sense that she was secure, confident and knew how to get things done. Her mother, to this day, comes across as weak and needy and looks to Sandy to provide her the strength she does not have. After her father's death, Sandy's feelings of not having a parent there for her who is capable and strong intensified considerably.
(b) Schemas	Subjugation, Self-Sacrifice, Negativity/Pessimism, Unrelenting Standards/Hypercriticalness

7.3 Possible temperamental/biological factors

List facets of temperament and other biological factors that may be relevant to your client's problems, symptoms and the therapy relationship. You are advised to read the instructions in the **Case Conceptualization Guide** carefully, as these address the difficulty in separating innate biological factors from the results of adversity and unmet needs, and the recognition of neurodiversity. See the **Case Conceptualization Guide** for a list of specific adjectives frequently used to describe temperament. It is sufficient just to list some of the adjectives from the list in the guide but you can give a fuller explanation where appropriate.

Submissive, pessimistic, prone to negative feelings. Easily overwhelmed. It is hard to separate out these factors from learned behaviors, given the dysfunctional nature of the family.

7.4 Possible cultural, ethnic and religious factors

If relevant, explain how specific norms and attitudes from your client's ethnic, religious, and community background played a role in the development of their current problems (e.g., belonged to a community that put excessive emphasis on competition and status instead of quality of relationships).

Sandy was raised in an environment where a girl's status was elevated by good looks and a slim body. This was communicated to her by her mother who was very conscious of her looks and weight. She experienced the same values from her peers who teased her for being chubby when she was young and were more accepting of her when she lost weight.

8. Most relevant early maladaptive schemas (currently)

8.1 List all the early maladaptive schemas you identified in section 7.2 above.

Schemas identified in 7.2	Emotional Deprivation, Defectiveness/Shame, Failure, Dependence/Incompetence, Social Isolation/Alienation, Abandonment/Instability, Mistrust/Abuse, Subjugation, Self-Sacrifice, Approval/Recognition Seeking, Emotional Inhibition Negativity/Pessimism, Unrelenting Standards/Hypercriticalness.

8.2 Select the 4-6 schemas that you consider *most central to your client's current life problems*. The main focus should be on **primary (unconditional)** schemas – you are advised to read carefully the instructions for this in the **Case Conceptualization Guide**. Specify the name of the schema, then, briefly describe your client's experience when this schema is activated with respect to such aspects as emotion, beliefs, somatic experience. Do not go into detail about coping patterns which are the focus of the following section.

8.2.1 Early maladaptive schema:	Emotional Deprivation
Description of pattern when activated	She feels a painful emptiness and a deep longing for connection but without any expectation that she will find it. She has the sense that "I will never find what I need."

8.2.2 Early maladaptive schema:	Abandonment/Instability
Description of pattern when activated	She is afraid to let herself get close to anyone, because this quickly evokes a fear that they will leave. At times she feels alone and bleak, as if she has been feeling some support but has suddenly been dropped. She once expressed it as, "I am alone and they are not coming back."

8.2.3 Early maladaptive schema:	Defectiveness/Shame
Description of pattern when activated	She feels inadequate, as if something is wrong with her. She believes she is worthless, unlovable and that no one would ever be interested in getting to know her or would ever see her as a valuable person. At times this is associated with an image of herself shrinking and becoming very small.

8.2.4 Early maladaptive schema:	Dependence/Incompetence
Description of pattern when activated	She believes she is not competent and so does not trust her own judgment. She believes she needs others to guide and reassure her. She has thoughts like, "I can't do this," "What if I get it wrong?" "I need someone to guide me on this."

8.2.5 Early maladaptive schema:	Social Isolation/Alienation
Description of pattern when activated	She feels different from other people and that she does not belong or fit in. She believes that because of this any attempt to reach out for meaningful human connection will be unsuccessful.

8.2.6 Early maladaptive schema:	Mistrust/Abuse
Description of pattern(s) when activated	She has a deep mistrust of others in all situations. She does not expect anyone to be reliable in caring for or respecting her, and she anticipates that she will be unpredictably hurt or attacked.

9. Most relevant schema modes (currently)

9.1 Healthy modes

Use the tables below to summarize the main features of your client's healthy and adaptive functioning.

9.1.1 Happy Child mode

Summarize the extent to which your client is able to experience being peace-filled, content and satisfied, as well as genuinely spontaneous, playful, carefree, and creative. This refers to authentic experiences and does not include showing any of these qualities in a superficial way, while in a coping mode.

Capacity for naturalness and spontaneity	There is no evidence of this in her life at all.
Capacity for playfulness and having fun in an innocent way	There is no evidence of this in her life at all.
Capacity to be creative	In her business she shows creativity in designing the savory menu items that she sells, and this originality contributes to her business success.

9.1.2 Healthy Adult mode

Summarize your client's Healthy Adult strengths, using the headings below. See the **Case Conceptualization Guide** for a fuller account of how the Healthy adult is conceptualized. Under each heading, include one or more examples related to specific life areas. You can also include examples related to your client's capacity to engage in the therapy process in a mature and collaborative way. Where the capacity is compromised or limited, draw attention to this, with examples, if possible.

1. Meta-Awareness: The capacity to step back and reflect on self and others	This is very limited. She finds it very difficult to step back and reflect. In the therapy she has been able to recognize that her Eating Disordered Overcontroller, her self-soothing through overworking, and her worrying and rumination are coping modes. However, this has not allowed her to step back and separate herself from them enough to be able to limit these activities in any meaningful way.

2. Emotional Connectedness: The capacity to be open to and experience emotions, and to be self-accepting and compassionate when experiencing emotional pain and uncertainty	This is very poor. Her Eating Disordered Overcontroller and her Avoidant coping chronically disconnect her from her emotions and she is regularly self-critical.
3. Reality Orientation: The capacity to make, and act on, decisions that are reality-based	In her work situation, her business success is the result of her making reality-based decisions, even though she keeps seeking reassurance from employees about business decisions. In her social life, however, she is unable to be realistic about the extent of and causes of her loneliness in a manner that enables her to make meaningful changes.
4. A Coherent Sense of Identity: The capacity to sustain a coherent sense of who one is, with respect to personal beliefs, values, attitudes and motivations	Her sense of identity is tied to her overcompensatory Eating Disordered and her Perfectionist Overcontroller modes. This alternates with anxiety and depression and self-doubt when her vulnerable child is triggered, and she gets caught up in worrying and rumination.
5. Self-Assertiveness and Reciprocity: The capacity to stand up for oneself, while honoring reciprocity and congruent communication	She can be assertive to some extent at work, but there is limited capacity for reciprocity. When things don't work out, she becomes subjugated as she is out of touch with her own needs or blames others for her problems.
6. Agency and Responsibility: The capacity to take responsibility for, personal decisions, actions and their consequences.	In her work she does take responsibility, but she mostly takes too much responsibility for small mistakes or difficulty in solving problems. In her personal and social life, she feels trapped and helpless but is unable to take responsibility for the consequences of her avoidant coping or her eating disordered behavior.
7. Caring Beyond the Self: The capacity to engage with others, and within the society as a whole, with an open, straightforward and compassionate attitude	This is limited, as any care she shows to others comes from self-sacrifice and overly focusing on their needs at the expense of her own. This is especially the case in relation to her mother. She has little capacity for true compassion either towards herself or others.
8. Hope and Meaning: The capacity to find, and to keep, faith throughout hardships of life.	There is little evidence of this as most of her activity is strongly schema driven whether at work or in her personal life, manifesting in rigid over-compensatory coping modes, excessive rumination and worry, and chronic avoidance.

In sections 9.2 to 9.4 below, identify the modes that are most central to an understanding of your client's current life problems, and follow the instructions on how to present your responses.

9.2 Child modes (Do not include the Happy Child)

9.2.1 Vulnerable Child Modes

In the top row, identify the main features of your client's Vulnerable Child or list specific Vulnerable Child subtypes that are important for the conceptualization (e.g. Lonely Child, Abandoned Child, Shamed Child, Terrified Child, Abused Child, etc. …). Then, on the right, list the main schemas related to each mode or subtype you identify.

In the rows marked Ex 1, Ex 2, and Ex 3, give two or three examples of what happens when these modes are activated. See the **Case Conceptualization Guide** for accounts of what is needed under a, b, and c.

Vulnerable Child mode or subtype:		**Schema(s) that coincide with the mode**
Lonely Child		Emotional Deprivation, Social Isolation
Dependent Child		Dependence/Incompetence
Shamed Child		Defectiveness/Shame
Abandoned Child		Abandonment/Instability
Abused Child		Mistrust/Abuse
Ex 1	**a) Activated mode and example of a triggering situation**	Shamed Child: An acquaintance comments that now she has achieved a normal weight she will find a partner and have a loving relationship
	b) Experience of schema vulnerability (emotions, images, thoughts) while in the Child mode	A deep sense of shame. Thoughts: "If she only knew me, she would see how unlovable I am, in spite of the weight loss". Image of self as overweight and unattractive.
	c) Coping mode (if any)	Avoidant Protector; Anorexic Overcontroller, Flagellating Overcontroller

Ex 2	**a) Activated mode and example of a triggering situation**	Dependent Child: She has to order ingredients for the recipes they make, but she is uncertain whether to order a larger or smaller quantity.
	b) Experience of schema vulnerability (emotions, images, thoughts) while in the Child mode	Feels incompetent. Thought: "I can't decide this on my own." Image of herself age 7 not knowing how to play a game that her father and brother are playing.
	c) Coping mode (if any)	Worrying ruminator. Reassurance Seeker.

Ex 3	**a) Activated mode and example of a triggering situation**	Lonely Child: She is alone at home after having worked late.
	b) Experience of schema vulnerability (emotions, images, thoughts) while in the Child mode	She feels a painful emptiness. Thoughts: "I will never find someone." Images of herself all alone. Image of herself as much older and still alone.
	c) Coping mode (if any)	Depressive Ruminator; Detached self-soother (comfort eating).

9.2.2 Other Child Modes

At the top, describe one or more other child modes such as the Angry Child, Enraged Child, or Impulsive Child. Then, on the right, list the main schemas related to each mode or subtype you identify. Use the rows marked Ex 1, and Ex 2 to give one or two examples of what happens when these modes are activated. See the **Case Conceptualization Guide** for accounts of what is needed under a, b, and c.

Other Child modes		**Schema(s) that coincide with the mode (if any)**
Angry Child		
Ex 1	**a) Activated mode and example of a triggering situation**	Angry Child: triggered by reminders of her father, who largely ignored her, and failed to protect her when she was bullied at school and died suddenly.
	b) Experience of schema vulnerability (emotions, images, thoughts) while in the Child mode	Anger. Somatic tension. Thought: "He didn't care. He just left me." Image of her father lying on the floor in the kitchen the day he died.
	c) Coping mode (if any)	Angry rumination.
Ex 2	**a) Activated mode and example of a triggering situation**	Angry Child: triggered when her mother arrives in her office expecting her to sit and chat with her when she wants to be working.
	b) Experience of schema vulnerability (emotions, images, thoughts) while in the Child mode	Thoughts: "She doesn't care; she doesn't see me; she's such a pain; she is so inconsiderate I can't do anything to stop her." Images of herself shouting at her mother.
	c) Coping mode (if any)	Compliant Surrenderer, Avoidant Protector

9.3 Dysfunctional parent modes

See the **Case Conceptualization Guide** for a definition and comprehensive list of possible parent modes. In the table below, list the most prominent parent modes you have identified, whether these are distinct or blended with other parent features.

For each mode, give one or two examples of the kinds of messages (explicit or implicit) that the child picks up from the internalized parent.

Parent mode or feature	**Examples of explicit or implicit messages to the child**
Critical	"You have let me down; you are a disappointment." "You are not good enough," "You are too incompetent to make even the simplest decisions".
Rejecting	"No one is interested in you; you are a burden."
Abandoning	"You can't rely on me to stay with you."
Humiliating	"There is something wrong with you." "With looks like yours, you will never get a man interested in you."
Guilt-inducing	Mother's voice: "Can't you see that I am lonely, I need you to spend time with me. How can you be so selfish and not see that?"
Neglectful	"We all have our own interests and activities and lives to lead, and you are simply not of value or importance to us."

9.4 Maladaptive coping modes

In the table below, list the most prominent coping modes you have identified, and classify them under the broad categories of Detached/Avoidant, Surrender, Overcompensator, etc. In the right-hand column, list schemas that coincide with each mode (if any). See more detailed instructions in the **Case Conceptualization Guide**.

Coping mode category	Coping mode	Schemas that coincide with the mode
Overcompensation	Perfectionist Overcontroller	Unrelenting standards
Overcompensation	Eating disordered overcontroller	Unrelenting standards
Overcompensation/Rumination	Flagellating Overcontroller	Unrelenting standards
Detached/Avoidant	Detached Protector	Emotional Inhibition
Detached/Avoidant	Detached Self-Soother	
Detached/Avoidant	Avoidant Protector	
Surrender	Compliant Surrenderer	Subjugation
Surrender	Helpless Surrenderer	
Surrender	Reassurance seeker	Dependence/Incompetence
Surrender	Self-sacrificing rescuer	Self-sacrifice
Rumination	Ruminator (Worrying, Depressive, angry)	Negativity/Pessimism

Select **up to three** of these coping modes and describe in detail your client's experience when in the mode, using the tables below. See the **Case Conceptualization Guide** for details of what is required in each of the sections a – e.

9.4.1 Name of mode

	Detached self-soother
(a) Example of a situation	At the end of the workday, when employees have gone home.
(b) Experience and behavior while in this mode	She feels alone and depressed. She stays at work focusing on work tasks and working late, sometimes only going home after 10:00pm
(c) What the mode is coping with in the Child	Lonely Child
(d) Perceived value of this mode for client	Keeps the loneliness at bay
(e) Problematic consequences for client	Perpetuates her loneliness as it prevents her making friends or developing meaningful relationships.

9.4.2 Name of mode

Eating Disordered Overcontroller

(a) Example of a situation	This has become a chronic default mode. She is constantly preoccupied with her food rules and areas of her body that she perceives as not slim enough. Her restricting behavior increases in response to any situation that activates her loneliness or sense of shame and incompetence.
(b) Experience and behavior while in this mode	Focusing on implementing her restrictive food rules shuts out painful emotions and gives her a sense of power and being in control. However, after binging or eating forbidden foods, she urgently focuses on getting rid of the food by vomiting (which can happen as much as three times a day) and afterwards feels shame and self-disgust.
(c) What the mode is coping with in the Child	Loneliness, shame, failure, Dependence/incompetence
(d) Perceived value of this mode for client	She gets a sense of being in control and can shut out painful, confusing, and distressing emotions.
(e) Problematic consequences for client	She is constantly preoccupied with these thoughts and behaviors. She is also aware of the risks associated with regular induction of vomiting. On two occasions she was found to be hypokalemic on blood tests and the dentist has warned her of erosion of tooth enamel. This preoccupation contributes to her avoiding meaning contact with others and maintains her loneliness.

9.4.3 Name of mode

Anxious rumination and reassurance seeking

(a) Example of a situation	Sandy has to make a decision at work such as how much stock to order.
(b) Experience and behavior while in this mode	She feels unsure about the decision and is afraid of making a mistake, and, as a result, feeling shamed and incompetent. She ruminates anxiously about the different options she has in an ineffective manner. She then seeks advice and reassurance from her employees who are not particularly competent to advise her.
(c) What the mode is coping with in the Child	Fear of being shamed and shown up to be incompetent.
(d) Perceived value of this mode for client	She hopes that through the rumination and reassurance seeking she will solve the problem of how much to order
(e) Problematic consequences for client	Her worrying and reassurance seeking maintain a state of constant anxiety. Even when she makes effective decisions, she does not learn from them or trust her capability

10. Mode sequencing and schema perpetuation

In this section you should show how a trigger event can set in motion a sequence of modes that unfolds over time, sometimes in response to the reactions of others to behaviors early in the sequence. Identify and name all the modes involved – child modes, parent modes, and coping modes. Healthy modes may also be involved but the focus is on sequences that lead to schema perpetuation, and so do not end in the Healthy Adult mode.

Give at least three examples of events in your client's life that show how your client's dysfunctional modes are perpetuated. These should illustrate one or more of the specific Life Areas identified as problematic in section 5.1 above. You can introduce new examples, or, if you like, you can repeat examples you already used in section 9.4 above (where the main focus was on a single coping mode).

Describe the trigger situation and then, provide the specific information referred to in each of the rows (a) to (e) below. For details and examples of what is required in each row, see the **Case Conceptualization Guide** and the **Case Conceptualization Clinical Example**.

10.1 Trigger situation:	Sandy's mother appeared at her place of work at lunch time and sat down in her office and started chatting
a) Child and parent modes activated (or hidden by the coping/avoided)	Sandy feels pressured to entertain her mother and be polite (Demanding and Guilt-Inducing Parent/Shamed Child). She is also frustrated that her mother's being there is interrupting her and taking her away from her work (Angry Child).
b) Coping mode(s): Name and behavior	Compliant Surrenderer: Tries to please her mother. Angry Protector: Puts up a wall of anger and pushes her mother away (emotionally). Avoidant Protector: After a while, she leaves the office and leaves her mother alone.
c) Mode sequence	Although she feels invaded and angry, she suppresses her anger and tries to accommodate her mother's needs because she is afraid of her and also because she feels sorry for her and responsible because she is so alone (Compliant Surrenderer). Eventually she becomes more visibly angry but only expresses it indirectly (Angry Protector). She tells her mother there is something urgent she needs to attend to, which is not true (Compliant Surrenderer) and walks out leaving her mother alone (Avoidant protector).
d) Effect of coping on the situation, on other people, and/or on the client	Once she leaves the office, she feels frustrated and panicky and finds it difficult to focus on her work (Ruminator). She knows her mother will eventually leave, and that later she will reproach her for her not staying with her and, as she ruminates, her emotions change from anger to anxiety to the shame she will feel when her mother blames her later.
e) Explain how the coping is self-defeating / schema-perpetuating	The Compliant Surrender, Avoidant Protector, Angry Protector and Rumination all mute or shut down her anger and prevent her from being assertive with her mother, which she would need to do to reach a long-term solution. As a result, her own needs continue to be unmet. It also sets her up for occasional angry outbursts at her mother, which she feels guilty about afterwards.

10.2 Trigger situation:	At a workshop at the Chef's Club which she attended to get new ideas for the meals she prepares, another woman attendee suggested they meet for coffee to talk about the work they do
a) Child and parent modes activated (or hidden by the coping/avoided)	She felt anxious and had thoughts like, "She won't really like me if she gets to know me. She will see how stupid and incapable I am" (Defective / Humiliated Child – Rejecting Parent /Shaming Parent). She quite liked the woman but was aware that, if she let herself start to connect with her, she would expect to be abandoned (Abandoning Parent- Abandoned Child). She also anticipated having to eat and drink items that were not on her list of allowed foods and this evoked anxiety and anger (Eating Disordered Overcontroller - Angry Child).
b) Coping mode(s): Name and behavior	Eating Disordered Overcontroller: Aware of her food rules. Avoidant Protector: Feel anxious and refuses the invitation, avoids physical proximity to the woman. Flagellating Overcontroller: Becomes hypercritical of herself, blaming herself for perpetuating her loneliness. Detached Self-Soother: Binge eats and induces vomiting. At home she watches TV mindlessly.
c) Mode sequence	Sandy said it was hard to see which came first. The Defective/Humiliated Child – Rejecting, Shaming Parent, and the Abandoned Child – Abandoning Parent) seemed to be there together. Then the pressure to eat something that would violate her food rules (Eating Disordered Overcontroller) was quickly added to that. She immediately refused the invitation saying she had a lot of work pressure at present and would not have the time (Avoidant Protector). She continued to avoid being physically close to the woman for the rest of the workshop (Avoidant Protector). Afterwards at home she got caught up on self-attacking rumination (Flagellating Overcontroller). She distracted herself by watching TV and snacking on a lot of food and eventually inducing vomiting (Detached Self-Soothing modes)
d) Effect of coping on the situation, on other people, and/or on the client	Probably the woman who invited her was confused and puzzled by her reaction, perhaps even disappointed and hurt, and unlikely to repeat the invitation in the future. This contributes to the perpetuation of her loneliness. Once away from the workshop, Sandy's self-criticism distressed her further, leading to all the self-soothing activities she uses to distract herself.
e) Explain how the coping is self-defeating / schema-perpetuating	All these coping modes prevent Sandy from making meaningful connections with other people and perpetuate her loneliness and her sense of defectiveness and incompetence.

10.3 Trigger situation:	Sandy must make a decision at work such as how much stock to order.
a) Child and parent modes activated (or avoided or hidden by the coping)	She feels unsure about the decision (Dependent Child/Neglectful Parent) and is afraid of making a mistake (Scared Child/Punitive Parent+Shamed Child/Humiliating Parent.
b) Coping mode(s): Name and behavior	Ruminator: Ruminates unproductively about the decision. Helpless Surrenderer: She freezes and feels paralyzed. Reassurance seeker: She approaches employees and anxiously seeks their advice about the decision.

c) Mode sequence	She ruminates anxiously on the decision and the different options in an ineffective manner (Ruminator). She becomes more and more agitated and anxious and then she freezes and feels completely helpless (Helpless Surrenderer). Eventually she seeks advice and reassurance from her employees who are not particularly competent to advise her (Reassurance Seeker).
d) Effect of coping on the situation, on other people, and/or on the client	Her employees lose respect for her as they feel irritated by her. But they try to be patient and do their best to give her the reassurance she is seeking.
e) Explain how the coping is self-defeating / schema perpetuating	Her inability to solve the problem by herself perpetuates her sense of incompetence and dependency. She can sense the employees' irritation, and this adds to the shame she already feels (Defectiveness/Shame schema). This prevents her from ever developing a Healthy Adult way of dealing with stock ordering.

11. The therapy relationship

11.1 Therapist's personal reactions to the client

Describe your personal reactions to your client, **both those that are facilitative for the therapy and those that are problematic.** For facilitative reactions, briefly describe how they contribute to a meaningful therapeutic relationship. For problematic reactions, identify the client characteristics/behaviors that trigger them. When this happens, what schemas and modes are activated in you? What impact do your reactions have on the treatment, particularly with respect to your capacity to offer reparenting to this client?

At first Sandy was very detached and her limited progress activated my Defectiveness schema. I would focus excessively on the case conceptualization and rationale for therapy but in a way that was overly intellectualizing and that gave me a sense of control and competence. I felt overly responsible for Sandy's slow progress and by joining her in intellectual analysis I thought I was going to be able to find a way to fix her problems. I now realize this was my own coping and it interfered with the process of helping her access emotions in the therapy process.

I am also affected by her Helpless Surrenderer mode which initially evoked a sense of helplessness in me, but also frustration and anger at her unwillingness to help herself. However, now I have come to accept the reality of the challenge of working with her and the need for me to be patient and systematic with reparenting in the relationship.

11.2 Collaboration on therapy objectives and tasks

See the **Case Conceptualization Guide** for a detailed definition of collaboration, and for details of the scale (from 1 to 5) to be used for making your rating below.

11.2.1 Rating of degree of collaboration on objectives and tasks: **2**

11.2.2 Describe the collaborative process with the client

Explain the basis for your rating by describing the ways in which you and your client have been able to work together that have been positive, with respect to contributing to effective collaboration, and aspects of the relationship that are problematic, in that they interfere with effective collaboration. See the **Case Conceptualization Guide** for some suggestions.

Although at times Sandy accepts some of the active goals for therapy, described in section 12 below, and recognizes that she will need to change if she is to be happier and more fulfilled, most of the time she is unable to actively work on goals that involve reaching out to people as a way of finding meaningful relationships. When I raise this with her, she shuts the topic down and changes the subject.

11.2.3 How could the collaborative relationship be improved?

Where collaboration is moderate or low, identify the barriers and obstacles to collaboration and outline what changes need to be made to address them. See the **Case Conceptualization Guide** for more detailed suggestions.

Due to dominance of her Eating Disordered Overcontroller, and Ruminator and Avoidant coping modes, it is very hard to engage her in collaboration on behavioral goals, and it is probably too early to focus on this at this stage. However, she has been attending more regularly, which suggests she has been experiencing some benefit from being with someone who is open and non-judgmental, and she is very slowly developing some tolerance for vulnerable emotions. For the present therefore, it seems best to focus on providing more intense reparenting in the relationship and modelling the expression of emotion.

11.3 Reparenting relationship and bond

11.3.1 Rating of the reparenting relationship and bond: **3**

Read the definition of the Reparenting relationship and bond in the **Case Conceptualization Guide** and then use the rating scale described there (from **1-Weak** to **5-Strong)** to make your rating. Type the rating into the box above.

11.3.2 Describe the reparenting relationship and bond between the client and therapist

Give a description of your client's behaviors with you, the therapist, that are relevant to their openness to receiving reparenting. Provide details and examples of your client's behaviors, emotional reactions, and statements in relation to you that serve as indicators of how weak or strong the reparenting bond is.

At first, Sandy could not access any vulnerable emotions. When she had not completed the homework perfectly, she expected me to judge her. In due course, she came to recognize that I was not critical and judgmental like her mother (and brother). She was able to be open to my acceptance and validation of her needs and emotions and found it easier to access some vulnerability in sessions. When she has been vulnerable in a session, she has found it rather uncomfortable, but, at times, I have felt like giving her a hug afterwards. However, when I gently offered this, she declined. This illustrates how deeply she craves connection and care yet is unable to receive it. Despite this, a reparenting bond has been established and she is increasingly able to engage with my empathic understanding of her loneliness. She also uses me as a guide as to whether the emotions she experiences in her life situations are genuine or not.

11.3.3 How could the reparenting relationship and bond be improved or strengthened?

Where the reparenting bond is not strong, explain what seem to be the obstacles to there being a stronger bond, whether these come from your coping modes or those of your client. What specific steps could the therapist take to strengthen the bond?

I believe our bond will continue to strengthen as I continue to show consistency in my care for her, in being gentle and warm when I see her, in being accepting of her reactions to whatever she shares, and in my encouragement of her achievements. However, Sandy still never reaches out to me between sessions in any way, despite the invitation to do so. Her recent tendency to cancel appointments has slowed the flow of her progress and may be a response to my putting too much pressure on her to work on behavioral goals. I need to gently, but empathically, confront the avoidant coping and work towards establishing a firm commitment from her to attend regularly. I need to name her difficulty in trusting me in an empathic manner. I also need to empathically confront her irregular attendance and share its impact on me in a non-judgmental manner.

11.4 Other less common factors impacting on the therapy relationship (Optional)

If there are any other factors that significantly influence, or interfere with, the therapy relationship (e.g., significant age difference, cultural gap, geographic distance), elaborate on them here. How could they be addressed with your client?

N/A

12. Therapy objectives: Interventions, progress and obstacles

Select at least four therapy objectives that are central to your work with this client. Objectives should be such that you, as the therapist, can help your client work towards them by working on identifiable therapy tasks. They can be described in relation to change with respect to specific schemas, modes, cognitions, emotions, behaviors, relationship patterns, symptoms, etc.

Summarize each objective and then provide further information in the rows below. See the **Case Conceptualization Guide** for more details of what is required. You can briefly refer to additional important objectives in Section 12.5.

12.1 Therapy objective:	To follow the dietician's meal plan and eat a normal diet that will allow her to maintain her weight without restricting (and setting herself up for binge eating and inducing vomiting)
(a) Schemas and modes to target	She will need to learn to become aware of the role of her Eating Disordered Overcontroller, her Perfectionist Overcontroller, her Flagellating Overcontroller and her Ruminator modes. She will also need to become more tolerant of Vulnerable Child feelings of loneliness and defectiveness.
(b) Relevant Healthy adult behaviors	Strengthening her meta-awareness of these coping modes so that she can genuinely re-evaluate their role in her life and see how they keep her trapped. Increasing her tolerance for vulnerable emotions that feel distressing, confusing, and out of control.
(c) Interventions and rationale	Chairwork to help her identify and separate from these coping modes so that she can re-evaluate their role in her life. Cognitive restructuring to help her build reality-oriented attitudes and beliefs to replace the schema driven ones. Regular and systematic monitoring of her attempts to implement the diet plan and examination of the processes that take place when she does not go through with it.
(d) Progress and obstacles	She has been able to show some meta-awareness of these coping modes in response to chairwork. However, this is not sustained outside of sessions. She has made only limited progress in following the diet plan, and she reverts to her old patterns whenever anything happens to distress her. She copes by being dismissive in sessions or skipping sessions altogether.

12.2 Therapy Objective:	For Sandy to reduce her anxiety when making decisions, particularly at work.
(a) Schemas and modes to target	Defectiveness/Shame, Dependence/Incompetence, Failure, Negativity/Pessimism schemas. Ruminator mode, Helpless Surrender mode, Reassurance Seeker mode.
(b) Relevant Healthy adult behaviors	Meta-awareness of these coping modes so that she can interrupt them. Self-compassion for the Vulnerable Child emotions
(c) Interventions and rationale	To help her recognize the coping modes and see how they perpetuate her problems and to evoke and offer reparenting to her Vulnerable Child in the relationship and in imagery, through imagery rescripting. To teach her cognitive restructuring, anxiety management strategies combined with mindfulness and/or relaxation. Use of flashcard, coping imagery.
(d) Progress and obstacles	In sessions she can acknowledge that the coping modes are not helpful and can recognize that they contribute to her anxiety and depressed mood. However, outside sessions she cannot sustain this and she has not followed up suggestions that she monitor it at home. When we attempt imagery work, her Detached Protector often gets activated and she cannot receive the reparenting the Vulnerable Child needs.

12.3 Therapy objective:	For Sandy to increase her tolerance of genuine emotions and learn ways to communicate them in the therapy setting.
(a) Schemas and modes to target	This will involve recognizing and re-evaluating all her coping modes and experientially accessing the Vulnerable and Angry child and associated primary schemas such as Emotional Deprivation and Defectiveness.
(b) Relevant Healthy adult behaviors	Becoming aware of her emotional states, tolerating them, understanding their meaning, and finding ways to give them appropriate expression
c) Interventions and rationale	When there is direct or even indirect evidence of an emotional state, I seek to name it, empathize with it and normalize it. When she responds to this, I can work with her to find words that adequately express her experience. I need to do more experiential work (chair dialogues and imagery rescripting) to bypass her Detached Protector Mode and access her Vulnerable and Angry Child modes so that I can help her open up a pathway to reparenting them.
(d) Progress and obstacles	At first, I did not suggest this as an explicit goal for therapy as she was more open to concrete behavioral goals. When I recently suggested this as an explicit goal, she was skeptical and did not actively welcome it. However, I have gently and steadily persisted, and she is more able to engage with this as a goal.

12.4 Therapy objective:	For Sandy to change the relationship with her mother by spending less time with her and expressing her own needs more when she is with her.
(a) Schemas and modes to target	This would target her Emotional Inhibition, subjugation and defectiveness and the associated lonely and shamed child and her coping through compliant surrender, rescuing/self-sacrificing, avoidant protector, angry protector and detached self-soother.
(b) Relevant Healthy adult behaviors	To learn to express herself assertively to her mother when she visits, to offer her mother a limited number of specific times when she can visit her, and to be firm about not being available if she comes at other times.
(c) Interventions and rationale	Imagery rescripting to address the internalized guilt-inducing parent. Giving her guidance on how to assert herself and be more honest in the relationship. Imagery rehearsal of assertive behavior.
(d) Progress and obstacles	There has been limited progress. Although, as therapist, I have recommended this as a goal, most of the time Sandy is not committed to it and avoids working on it. Her Self-Sacrifice schema and her loneliness both impair her motivation and are obstacles to progress. It is probably too early to work on this objective effectively and this may need to wait until she has made more contact with her Angry Child and is comfortable expressing that (Objective 12.3 above).

12.5 Other therapy objectives:	For Sandy to engage with other people in a more meaningful manner so that she can develop supportive friendships
(a) Schemas and modes to target	This would also target her Emotional Inhibition, subjugation and defectiveness and the associated lonely and shamed child and her coping through compliant surrender, rescuing, avoidant protector and detached self-soother.
(b) Relevant Healthy adult behaviors	She would need to reach out to others to build friendships and to engage in social and recreational activities that would bring her into contact with others outside the work setting and practice sharing her life and experience with some of them in conversation.
(c) Interventions and rationale	I have recommended that she reach out to others in the above ways and offered to guide her step by step in experimenting with this. I have offered to help her to identify triggers that lead to her withdrawing socially, such as reminders of her father and the anger this evokes, or her fear of her autonomy being taken away when the guilt-inducing parent is active.
(d) Progress and obstacles	Although she seems to understand the rationale for this intellectually, there has been no progress at all. When I raise the subject, she changes the topic or rationalizes about why she is not ready for this yet. I need to use more empathic confrontation to help her implement what she understands intellectually.

13. Additional comments or explanations (optional):

A note on some of the schema modes used in this Clinical Example

There is some diversity in the modes that are used within the schema therapy community. The *ISST list of schema modes - Supplement to the Case Conceptualization Guide* provides two lists, a basic list of those modes that are widely used by most schema therapists, supervisors and trainers, and an extended list that includes other modes from the recent literature. Some modes referred to in this clinical example are from the extended list. For those not familiar with them, this brief note should be enough to clarify their meaning. The references below point to the published literature where they are described and discussed. In writing your own case conceptualization you can use those modes that you and your supervisor are familiar with and there is no requirement that you draw on the more extended list, but this Clinical Example shows how they can be incorporated for those that wish to.

- **Eating Disordered Overcontroller:** This is a specialized form of Perfectionist Overcontoller that is commonly found in eating disorders: see Edwards (2017), Simpson (2020), Simpson et al (2018).
- **Self-Sacrificing Rescuer**: This kind of behavior has normally been included as part of the Compliant Surrenderer mode. However, Edwards (2022) suggests that it can be helpful to differentiate the self-sacrifice that is associated with the Self-Sacrifice Schema as a separate mode. This Self-Sacrificing Rescuer mode is also identified in Brockman et al. (2023, p. 282).
- **Reassurance Seeker**: Reassurance-Seeking is another behavior that has been typically included in the Compliant Surrenderer mode. It is included in the Approval/Recognition-Seeking schema and has been repeatedly identified in the CBT literature as perpetuating problematic psychological problems. For this reason, Edwards (2023) differentiates it as a separate Surrender mode.
- **Ruminator modes:** The CBT literature has recognized these coping behaviors for thirty years and differentiated several different categories. They have been identified as important for schema therapy by Brockman and Stavropoulos (2020), Stavropoulos, Haire, Brockman and Meade (2020), and Brockman et al (2023) who use the term Overanalyzer. Based on the CBT literature Edwards (2023) suggests there are several kinds of such rumination, not all of which fit with the term Overanalyzer. Those identified here are Worrying, Depressive Rumination, and Angry Rumination.
- **Flagellating Overcontroller:** This is a Critic mode that is a form of self-attacking rumination which Brockman et al (2023, p. 9), Edwards (2022), and Simpson (2018, p. 51) differentiate from the Punitive Parent because it is a coping mode.

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