Schema Therapy Case Conceptualization Guide
(Version 3.8)

Those completing the Schema Therapy Case Conceptualization Form are advised to pay careful attention to the instructions in this Guide

Overview

The purpose of this form is to enable you to structure information about the client in a manner that sets out a clear case conceptualization. The form is long and comprehensive. It is not expected that you will use it routinely for all your cases. It is required for those cases from which you are submitting recordings for evaluation and rating as part of the process of becoming certified by the ISST. However, it can also be used as a training tool. By completing the Case Conceptualization Form for one or two of your cases, and by attending to the instructions in this Guide, you can have a valuable learning experience in which you will get useful practice and enhance your understanding of how many of the central ideas in schema therapy work in practice.

The different sections of the form will also guide you in obtaining the basic information you need from the assessment phase of your work with the client, to serve as the basis for the case conceptualization. You can start entering information about a client on this form, and then update it with additions or modifications as new information comes to light.

At the top, provide the following information:

Therapist's Name: Name of the therapist treating the client and filling out the form

Date: The date the you finished filling out or updating this form

Number of Sessions: Number of sessions so far including the client's first session

Months since 1st Session: Number of months since the client's first session

1. Client Background Information

Client's Name/ID: The client's name, pseudonym, or identification code

Age/DOB: Enter the client's age on the date you completed this form, or the date of birth. You may also include both.

Current Relationship Status/Sexual Orientation/Children (if any): State client's relationship status (single, married, living together, etc.). What is the client's stated sexual orientation? Does the client have any children? If so, what ages?

Occupation and Position: What is the client's career or occupation? What level is the client within this career (e.g., top-level executive, self-employed, supervisor)?

Highest Educational Level: What is the highest level of education the client has completed?

Country of Birth/Religious Affiliation/Ethnic Group: List the client's country of birth and religious affiliation. If relevant, include the client's ethnic background.

2. Why is the Client in Therapy?

Summarize the client's motivation for coming for therapy ***in the first place***.

Describe those aspects of the client's life circumstances, significant precipitating events, or problematic situations (conflict at work or in a romantic relationship) or distressing emotions or behaviors (e. g. substance dependence or abuse, eating disordered behavior, angry outbursts) or other symptoms (anxiety, low mood, traumatic flashbacks) that the client sought help with. Do not include here significant problems that the client is not explicitly wanting help with. You will provide details of these in section 5. Describe the current level of distress and indicate whether the client sought help voluntarily or under pressure from a relative or work supervisor.

If the client has been coming for many sessions, summarize the situation ***currently*** and indicate whether what the client is seeking help for has changed from what was presented initially.

3. General Impressions of the Client

Using *everyday language*, briefly describe how the client comes across in a global sense during sessions (e.g., reserved, hostile, eager to please, needy, articulate, unemotional). Do not use technical psychological concepts here. Do this for how you experienced the client at the ***initial*** sessions, as well as ***currently***. Do not comment on the therapy relationship here as this will be addressed later in section 10.

4. Current Diagnostic Perspective on the Client

Main Diagnoses: List up to 4 psychiatric diagnoses that apply to the client. You may use the diagnostic categories of **either** the DSM-5-TR, **or** the ICD-11. Indicate in the box which system you are using. For each diagnosis, include both the *name and numeric code*.

The ISST recognizes that not all psychotherapists routinely give psychiatric diagnoses and that the requirement to do this varies across different countries and professional settings. In schema therapy, of course, treatment planning is not based on these diagnoses, but on the case conceptualization. However, it is recommended that certified therapists be familiar with one or other of these diagnostic systems because they are useful in three ways: 1) they focus attention on important information regarding symptoms and problems that might otherwise be missed; 2) much of the current research literature on schema therapy and treatment approaches is based on these diagnostic categories; 3) they are important when communicating with and/or collaborating with other health care professionals not familiar with the Schema Therapy model and its concepts.

5. Current Level of Functioning: Major Life Areas and Lifestyle

To obtain an overview of how well your client is functioning, consider the five life areas listed below, and their quality of lifestyle self-care, as summarized below.

Current Level of Functioning is defined as the quality of the client's current overall behavior in each individual life area. Use the rating scale below for this purpose. The rating should be based on the perspective of an *objective* observer using, as a comparison the "general public," or members of the community at large, as well as a clinical perspective as to what healthy functioning looks like. Rating should not be made in comparison to other clients or to some idealized view of how people should be.

Rating the Level of Functioning: In the two tables 5.1 and 5.2, use the 6-point scale below to rate the client's current level of functioning and enter the values into column 2.

1 = Not Functional or Very Low Functioning	**4 = Moderately Impaired Functioning**
2 = Low Functioning	**5 = Good Functioning**
3 = Significantly Impaired Functioning	**6 = Very Good or Excellent Functioning**

If there are circumstances beyond the client's control (such as age or a recent loss) that make it inappropriate to rate a particular category, write N/A (Not Applicable) in Column 2 and then explain why in Column 3.

Explanation or Elaboration: In the 3rd column, briefly explain why you rated the client as you did, for each category. If there is a significant discrepancy between the client's previous and current levels of functioning, elaborate on the change. For example, mention that the client had excellent relationships with friends prior to the onset of a major depression.

5.1 Major life areas

5.1.1 Occupational or educational performance: This refers to how well the client is functioning at work or in school or other educational setting, relative to both what is considered "normal" for the client's age and peer group, and to what the client is probably capable of (based on ability and background).

5.1.2 Intimate, romantic, longer-term relationships: This refers to relatively long-term relationships with intimate partners which would normally involve a romantic/sexual component during at least some periods. The main focus here is on marital or similar long-term committed relationships. Clients who only have shorter, relatively superficial, dating relationships would be given a low score on this life area.

5.1.3 Family relationships: This refers to the client's relationships with family members, including their own children, parents, grandparents, siblings, and other extended family members (e.g., uncles, cousins, nieces, in-laws). This category does not include romantic partners, such as husbands, partners with whom they are cohabiting or dating relationships.

5.1.4 Friendships and other social relationships: This refers to other types of ongoing social relationships not mentioned above. Special emphasis should be placed on current relationships with friends and, to a lesser degree, work colleagues. Involvement in other social relationships, such as with neighbors, community members, and clubs, can also be included in your rating.

5.1.5 Solitary functioning and time alone: This refers to the client's current level of ability, when alone, to find healthy meaning, focus and stimulation. This includes the capability to manage thoughts and feelings in a healthy way. Also include an evaluation of the client's ability to perform activities of daily living independently (e.g. budgeting, housekeeping activities, etc.) and also engagement in recreational activities (e.g. hobbies, creative activities) that are not of a social nature.

5.2 Lifestyle self-care: Exercise, diet, sleep patterns etc.

This refers to the extent to which the client has regular lifestyle habits that are likely to contribute to health and balance. Exercise includes sporting activities as well as activities like yoga, pilates, dancing etc. Consider the extent to which engagement in such activities is at an appropriate level and not too infrequent and not too obsessive. Similarly, consider the extent to which the client attends to personal hygiene and follows a healthy diet (based on current research recommendations e.g. Jacka et al. 2017), as well as whether they have regular healthy eating patterns (as opposed to rigidly restricting or switching from restricting to binging as in some eating disorders).

You can also include intake of alcohol and drugs (non-prescription and prescription). With respect to sleep, consider whether the client has a regular habitual sleep pattern and whether they get too little or too much sleep.

6. Major Life Problems

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

First name the problem as experienced by the client or as identified by you as the therapist, for example, Loneliness, Chronic Relationship Conflict, Persistent Anxiety, Procrastination, Obsessive-Compulsive behaviors, Excessive use of substances or prescription drugs. Then, in the space below, elaborate on the nature of each problem, and how it creates difficulties in the client's current life. Avoid technical language (such as reference to schemas and modes) in describing each problem or symptom.

If you list a psychiatric symptom (i.e. a specific feature used as a criterion for making a diagnosis in the ICD or DSM systems), it should be related to one of the diagnoses in Section 4 above. It may be appropriate to list several such features under a single problem area. For example, if the problem is clinical depression, this could include. as symptoms. such features as loss of interest in anything, feeling tired all day, difficulty concentrating, and disturbed sleep.

7. Childhood and Adolescent Origins of Current Problems

7.1 General Description of Early History

Summarize the important aspects of the 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. You should specify:

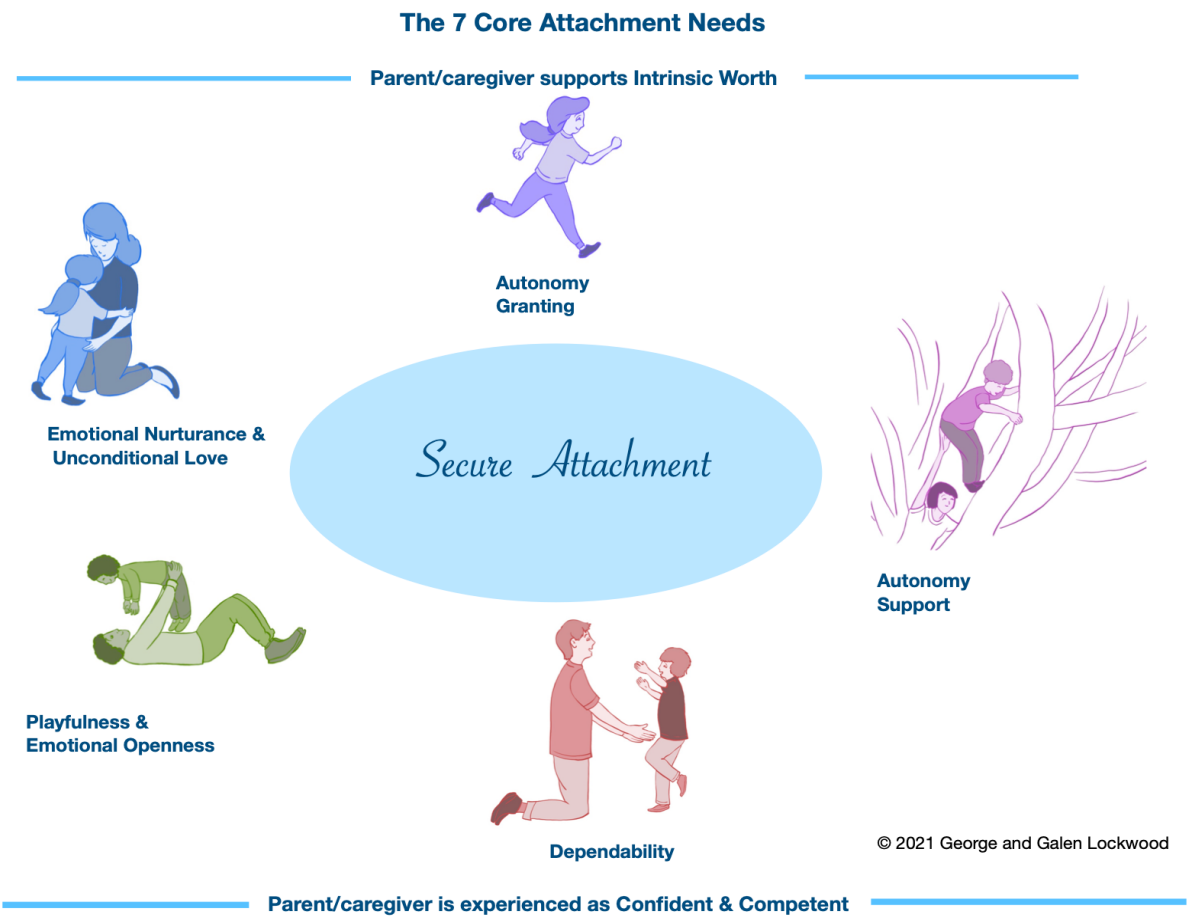
a) in which life areas or relationships these experiences occurred (e.g., cold mother, verbally abusive father, scapegoat for parents' unhappy marriage, unrealistically high standards, rejection or bullying by peers, punitive teacher at school);

b) at what developmental phase(s) the experiences took place: e.g. infancy and early childhood, middle childhood, adolescence;

c) how each of these specific circumstances or experiences affected the client emotionally.

7.2 Evaluation of Unmet Core Needs

In this section there is a list of nine core needs with respect to the child's relationship with their parents or other caregivers, particularly in the first years of life. The approach to categorizing core needs has been updated to reflect current developments in research. When Young initially summarized core needs under 5 headings (see Young, Klosko, & Weishaar, 2003) each need was linked to one of the five schema domains within which he classified the 18 basic Maladaptive Schemas. In practice not all these domains have been validated by research, and it is now recognized that a theory of needs is better based on what we know about adaptive parenting and adaptive functioning. Drawing on the work of Dweck (2017), Louis, Wood and Lockwood (2020) and Louis, Lockwood and Louis (2024) identified seven core needs. These are summarized in the figure below:



Emotional nurturance and Unconditional Love, Playfulness and Emotional Openness, Autonomy Granting, Autonomy Support, and Dependability are seen as the earliest emerging needs. The need for Intrinsic Worth comes into play as the child is helped to pursue goals and aspirations in a manner that achieves a balance between achieving an outcome on the one hand, and encouraging aspects such as authenticity, initiative, cooperation, and tenacity, on the other. As these needs are being met there is also a need to experience the parent/therapist as Confident & Competent (i.e. as being strong and able to "walk their talk"). The development of secure attachment is understood to be the outcome when all these needs are adequately met throughout the years of development.

On the case conceptualization form, this has been expanded to nine categories of core need. These are based on the above but two additional headings have been added that elaborate specific points that it is clinically valuable to highlight:

1) 7.2.2 is an elaboration of 7.2.1, the need for connection. This is included because of its centrality to understanding the problems many clients have in expressing their needs and emotions in words.
2) Similarly, 7.2.4 on the setting of firm limits, which is an aspect of 7.2.1 and 7.2.3, is also listed separately because of its significance for healthy development.

7.2.1 Need for connection (nurturance, acceptance, unconditional love): To meet this need, parents/caregiver must be able to attune to the experience and needs of the child, and provide a sense for the child of emotional connectedness, that their feelings are accepted, and that s/he is welcome and belongs. This also involves setting limits in a respectful and caring way but note that this is covered separately in 7.2.4 below.

7.2.2 Need for support and guidance in expressing and articulating needs and emotions and learning healthy socialization: To meet this need parents/caregivers must be attuned to the experience of the child and give him/her the language to verbalize their emotional states without shame or judgment. This supports the child in learning and practicing prosocial behaviors in social contexts.

7.2.3 Need for safety, dependability, consistency, and predictability: To meet this need, parents/caregivers must provide an environment that is stable and safe and within which they are reliable, consistent, and dependable in their responses to the child and to everyday situations.

7.2.4 Need for compassionate, firm and appropriate guidance and limit-setting to support the learning of realistic limits and self-control: To meet this need, parents/caregivers must be able to provide guidance and set limits in a firm, authoritative manner that is empathic, caring and non-punitive, and to support the child's learning appropriate control of emotions and impulses without excessive inhibition. While this is listed separately here, research has found that limit setting is an aspect of both Unconditional Love & Emotional Nurturance (7.2.1 above) and Dependability (7.2.3 above).

7.2.5 Need for support and encouragement of play, emotional openness and spontaneity: To meet this need, parents/caregivers must themselves be able to be spontaneous and playful and to support and make space and time for that in their children.

7.2.6 Need for affirmation of capability and capacity for development of competence (Autonomy Support): To meet this need, parents/caregivers must have faith in the child's ability to learn and grow into increasing competence and resilience in mastering new areas of life and meeting challenges, and to build on the positive rather than focus on mistakes and flaws.

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): To meet this need parents/caregivers must: allow children the freedom to make their own decisions and do things their own way when they feel like doing so, allow them increasing privacy as they get older, not dictate to them how to act, not overprotect them, and respect and encourage their development as unique and separate individuals.

7.2.8 Need for support and guidance in developing a sense of intrinsic worth that is not dependent on being better than others: To meet this need, parents/caregivers must support the child in being true to himself/herself, rather than trying to impress others, and to instill the value that all people are of equal value regardless of status or wealth or success.

7.2.9 Need for a parent/caregiver who is experienced as confident and competent: To meet this need parents/caregivers must give the child the implicit message that they are strong, wise, assured, and capable of handling the practical aspects of life. This provides the basis for the child to feel confident in their support, to know they are in strong and competent hands, and to trust that they can just be a child and focus on age-appropriate developmental tasks.

To complete section 7.2, go through the following steps for each need:

- Evaluate the extent to which the need was met, using the scale in the form itself. To make this rating, draw on 1) information from the client's account of their history, 2) information gathered from instruments such as the YSQ and YPI, 3) information that has emerged during sessions, particularly when using experiential techniques such as imagery assessment exercises, 4) any additional information obtained from collateral sources such as meetings with family members (where available).
- In the space for **Origins,** summarize significant features of the parenting received by your client. It is important to recognize that there are different needs at different life stages (for example, infancy, early childhood, middle childhood, adolescence). In some cases, needs may have been poorly met throughout, while in other cases, needs may have been better met at some stages than at others due to changes in the family (e.g. separation, divorce, financial crisis) or traumatic events (e.g. severe illness or death of a family member).
- Identify and list specific Early Maladaptive Schemas that developed due to this need not being adequately met. **Note**: There is not a one-to-one relationship between specific schemas and specific needs. Several different unmet needs may contribute to the development of any single schema so that the same schema may be listed under more than one need.

7.3 Possible Temperamental / Biological Factors

List facets of temperament that may be relevant to the client's problems, symptoms and the therapy relationship. Although you may use other descriptive words, it is sufficient just to select adjectives from the list below that convey aspects of the client's basic temperament.

Emotionally stable	**Introverted**	**Fearful**	**Forms Intense Attachments**
Even-tempered	**Sedentary**	**Withdrawn**	**Oblivious/ Under-reactive**
Optimistic	**Placid**	**Meek/Submissive**	**Inattentive to signs of threat**
Resilient	**Passive**	**Reserved**	**Overly Agreeable**
Warm	**Cooperative**	**Cautious**	**Overly Controlled**
Empathic	**Outgoing**	**Irritable**	**Overly Organized**
Social	**Extraverted**	**Impulsive**	**Dominant**
Confident	**Adventurous**	**Prone to negative feelings**	**Callous**
Cheerful	**Energetic**	**Pessimistic**	**Antagonistic**
Resourceful	**Hyperactive**	**Easily Overwhelmed**	**Combative**

Although temperament refers to characteristics that are biologically based and present from birth, it is recognized that, particularly where children are raised in adverse conditions, it is not possible to separate out features that are due to congenital biological factors, and those that are the result of parental neglect, inconsistency, abuse or other experiences of unmet needs. Include any biological factors that may have played a significant role in schema or mode development and relate to the client's problems, symptoms, and the therapy relationship. This includes factors such as height, medical conditions and factors that reflect neurodiversity, including attention deficit, hyperactivity or autistic spectrum features.

7.4 Possible Cultural, Ethnic and Religious Factors

If relevant, explain how specific norms and attitudes from the client's religious, ethnic or 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 on quality of relationships).

8. Most Relevant Early Maladaptive Schemas (Currently)

Section 8.1: Provide a list of all the Early Maladaptive Schemas you have identified. Just list the names and do not go into detail. You should already have named them in section 7.2 above, where each schema should be linked to one or more of the unmet needs.

Section 8.2: From the list of Early Maladaptive Schemas listed in section 8.1, select the 5 or 6 that are most central to the client's current life problems. In completing this section, it is important to

1. … pay attention to the difference between primary (or unconditional) and secondary (or c conditional schemas). Primary schemas are based on an emotionally painful, direct experience of unmet need: emotional deprivation, abandonment/instability, defectiveness/shame, dependence/incompetence, enmeshment/undeveloped self, failure, social isolation, vulnerability to harm or illness (trauma). Secondary schemas may, 1) reflect ways of coping with the primary schemas, so as to attenuate or avoid the pain: subjugation/invalidation, self-sacrifice, approval/recognition seeking, emotional inhibition, entitlement/grandiosity, or 2) include a mix of unconditional experience of pain and coping: mistrust/abuse, or 3) are features of overcompensatory coping and/or parent modes: unrelenting standards/hypercriticalness, or 4) include several consequences of primary schemas and coping: insufficient self-control/self-discipline, negativity/pessimism, punitiveness.
2. … recognize that where there are strong and entrenched coping modes, the client may provide little acknowledgement of or information about primary schemas. It is important that you identify primary schemas that are likely to be present, either from information in the history, or from how you experience the client in session.

The main focus should be on the primary schemas or other schemas which reflect primary schema experiences such as mistrust/abuse, insufficient self-control/self-discipline, negativity/pessimism, and punitiveness.

Put in the name of the schema and then describe the client's experience when this schema is activated with respect to emotions, cognitions (thoughts, beliefs, assumptions) and specific behaviors both external (observable) and internal (private sequences of thought, self-instruction, fantasy, etc). Do not go into detail about coping modes as these are the focus of section 9.4.

9. Most Relevant Schema Modes (Currently)

This form is built round the categorization of modes into Healthy Adult, Child, Parent and Coping modes. However, there is some diversity within the schema therapy community with respect to how specific modes are differentiated and named within these broad categories. A supplementary document entitled*: ISST list of schema modes - Supplement to the Case Conceptualization Guide* provides a summary of many of these modes. This is intended to be useful as a reference but is not intended to be prescriptive.

Section 9.1 Healthy Modes

9.1.1 Happy Child Mode

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

9.1.2 Healthy Adult Mode

This is the place to highlight the client's positive values, resources, strengths, and abilities. The **Healthy Adult** is not a single mode but a set of modes that are characteristic of how a mature, compassionate and psychologically minded person would think, feel and act in a particular situation. One aspect of the Healthy Adult is as an executive that can integrate the other modes and exercises capacities for self-regulation. It also includes the capacity for spontaneity, and authenticity and the kind of mature functioning that has been articulated by Alfred Adler (1938) as "community feeling" (Kałużna-Wielobób, Strus,& Cieciuch, 2020), by Carl Rogers (1967) as the "fully functioning person" (see also Maurer & Daukantaité, 2020), and by Abraham Maslow (1973) as "self-actualization" and "self-transcendence." Others have referred to it as "wisdom" (Baltes & Staudinger, 2000). David Bernstein's iModes cards, that pictorially represent 16 qualities of the Healthy Adult, draw on this vision of maturity. He groups them under four headings: self-directedness, self-regulation, connection and transcendence. The DSM-5 and ICD-11 diagnostic manuals also provide definitions of mature adult functioning which overlap with these qualities. They include having a coherent identity, and a sense of self-worth, capacities for emotion regulation and impulse control, and the ability to experience intimacy, and fulfillment (Bach & Bernstein, 2019). This view of Healthy Adult functioning also accords with perspectives from scientific research on happiness presented at the ISST's 2024 conference in Warsaw by Sonja Lyubomirsky and in her extensively researched books (Lyubomirsky, 2008, 2014).

These several qualities or strengths are summarized under eight headings which reflect the insights of the literature just referred. They are intended to be practical with respect to guiding clinicians in assessing (a) the degree of Healthy Adult qualities in a client, and (b) the kind of work in therapy that will be needed to build or strengthen the capacities that are poorly developed or missing. These headings should be seen as a guide rather than as an exclusive list.

Because the Healthy Adult encompasses diverse qualities, an individual can have some Healthy Adult capacities and strengths that are well established while others are poorly developed.

On the form you are asked to summarize the client's Healthy Adult strengths using the headings below, and, in each case, to include one or more examples related to specific life areas. You can also include examples related to the client's capacity to engage in the therapy process in a mature and collaborative way. Where the capacity is compromised or limited, you should draw attention to this, with examples, if possible.

1. **Meta-Awareness: The capacity to step back and reflect on self and others**

All major therapy approaches recognize the importance of the capacity to step back and reflect on one's own experience and that of others. In the literature, this is referred to by various terms such as "meta-awareness," "distancing," "decentring," "mentalization," "defusion," "mindfulness," "detached mindfulness," and "disidentification." At the beginning of therapy, many clients are caught up in their experience of their problems in an immersive way and have little or no capacity to step back and reflect on their experience. This makes it difficult to engage effectively with the processes involved in schema therapy.

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**

Carl Rogers used the term, "openness to experience" to refer this capacity to be humanly (emotionally) aware and present and intelligently engaged with what has meaning and feels authentic. This means being in touch with one's own personal needs and emotional responses to situations and being able to tolerate the emotions experienced. This includes the capacity for

acceptance and self-compassion (Neff, 2013). Coping modes interfere with this, as they disconnect individuals from the part of the autobiographical memory system that is connected to emotions and early schemas. The Healthy Adult has access to these emotions, but, by means of other capacities listed above, can exercise discrimination and self-control with respect to how needs, emotions and concerns are expressed. Openness to emotions also includes positive emotions, which also get shut down by coping modes, and allows in experiences such as gratitude and personal meaning.

3. **Reality Orientation: The capacity to make, and act on, decisions that are reality-based**

The Healthy Adult is oriented towards the realities of the world and has the capacity to make accurate, informed appraisals of everyday situations that are reality based, and not distorted by simplistic thinking or jumping to conclusions that are not adequately based on information and evidence. This includes facing painful aspects of reality and not denying or distracting from them through coping modes. Associated with this is the ability to use information obtained as the basis for engaging in rational, and practical problem-orientated behavior. This includes responsibly performing the practical tasks that are part of effective living in all important life areas (work, financial planning and management, family and intimate relationships, social activities, health and leisure activities). It also involves recognizing and identifying problems of all kinds, and taking steps so solve them in a Healthy Adult way. This requires the skills of searching for and obtaining information relevant to understanding a problem, evaluating sources of information, evaluating options for action, and planning and evaluating the chosen actions.

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**

This strength involves the experience of being grounded in a coherent sense of self that is consistent over time and through all significant life areas. This is accompanied by the capacity to accommodate a range of emotions and states, even when they are conflicting. Others are experienced as separate and independent centres of their own experience. There is an absence of abrupt transitions between self-states or modes and an absence of dysfunctional modes in which the individual experiences extreme states, for example, of chaos, fragmentation or merger with another. Memory is largely accurate and consistent and not confabulated or combined with fantasy. The individual's self-narrative (of who I am and what is important to me), is realistic and flexible and not marked by idealizations, oversimplifications, overcompensatory self-aggrandisement or self-identification as a victim.

5. **Self-Assertiveness and Reciprocity: The capacity to stand up for oneself, while honouring reciprocity and congruent communication**

Self-assertiveness, i.e. standing up for oneself in various regards is an important strength that helps define and protect the "I" in relation to others. Healthy Adult self-assertiveness is marked by the reciprocity principle and protects and promotes a sense of "We". Reciprocity is the basis for being able to engage in mature relationships in which there is mutual respect. This is at once a value and capacity. As a value, it means a commitment to having the same level of respect for the needs, perspectives, and experience of oneself and of others. As a capacity, it means being able act consistently on that basis. Self-assertiveness without reciprocity is usually a feature of overcompensatory coping. Reciprocity, when combined with emotional connection and tolerance, allows for congruent (Rogers, 1957) communication of experiences and needs, and the ability to make respectful compromises in conflict situations. This is the foundation of assertiveness training, a well-established approach in CBT (e. g. Alberti and Emmons, 2008). The reciprocity principle is also the basis for one's orientation towards the broader society in which one lives, with a capacity

for acceptance and absence of prejudice towards others on the basis of ethnicity, culture, religious affiliation, political affiliation, sexual orientation etc.

6. **Agency and Responsibility: The capacity to take responsibility for, personal decisions, actions and their consequences.**

The maturity of the Healthy Adult includes taking responsibility for all one's actions. This is associated with a sense of agency, feeling motivated and able to act in one's own interests and according to one's own values. This includes the capacity to make and keep commitments. These are all aspects of integrity – which means being consistent and trustworthy, and acting with a clear moral compass that is grounded in an authentic sense of self. Taking responsibility for one's own choices and actions is not usually possible when acting from coping modes. Individuals in a default coping mode such as an overcompensator are not fully in touch with their own needs and experience and the needs and experience of others, so that even if they act consistently there is usually an inflexibility and a lack of soundness in their decisions. Taking responsibility depends on the capacity to step back and reflect. Much human behavior occurs without conscious reflection, based on automatic coping habits that often developed long ago, and, when individuals behave automatically without reflection, they may have difficulty accepting responsibility for their actions.

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**

Community feeling is the term used by Adler (1938) to refer to those who have a sense of caring about and being motivated to strive for the common good, not just the good of oneself or one's immediate family. This is different from self-sacrificial coping and arises from a sense of self-worth based on what one has to offer, without any sense of having to prove one's worth. Such individuals have an attitude of kindness and compassion towards others, express spontaneous gratitude, and are committed to pro-social behaviors. They consider the effects of their actions not only from the immediate perspective, but also with respect to the effects for future generations (Kałużna-Wielobób et al. 2020).

8. **Hope and Meaning: The capacity to find, and to keep, faith throughout the hardships of life**

This refers to being able to find a path of hope and meaning, even when faced with adversities and loss. This arises from the capacity to look at oneself (and life as a whole) through a wider lens knowing that concepts such as good and bad, justice and injustice are complex. A person with this strength is able to accept not always having an answer to the question "why?", and can still move on in life with a sense of hope and meaning. Some would think of this strength as a natural wisdom or spirituality that provides a sense of strength and direction in the face of painful hardships and challenges. For some, this may be channelled through some form of institutional religion, while for others it is not linked to any formal framework.

Section 9.2 Child modes

9.2.1 Vulnerable Child

In the top row of the table, identify the main features of the client's Vulnerable Child or list specific Vulnerable Child subtypes that are important for the conceptualization (e.g. Lonely Child, Abandoned Child, Shamed Child, Dependent Child, Terrified Child, Abused Child, etc. …).

Then, in the right-hand column, list specific schemas associated with each mode or subtype. For example, for Dependent Child, put Dependence/Incompetence; for the Shamed Child, put Defectiveness/Shame.

In, in the three rows marked Ex1, Ex 2 and Ex 3, give three examples of what happens when one of these modes/subtypes is activated. Write a response to all three parts:

a) Name the specific mode and give a brief example of a trigger situation

b) Describe features of the client's experience of vulnerability while in this mode in terms of emotional overreactions, and schema driven images, thoughts and beliefs.

c) If the client flips into one or more coping modes, just name the mode(s) without going into detail, as you will be describing coping modes in section 9.4.

9.2.2 Other child modes

In this section, describe one or more other child modes such as the Angry Child, Enraged Child, or Impulsive Child.

At the top, name the mode or modes and list the schemas (if any) that are directly related to them.

Use the rows marked Ex 1, and Ex 2 to give one or two examples of what happens when these modes are activated. Use the three parts:

a) Name the specific mode and give a brief example of a trigger situation

b) Describe features of the client's experience of vulnerability while in this mode in terms of thoughts and beliefs, somatic symptoms, emotions, and images and memories.

c) If the client flips into one or more coping modes, just name the mode(s) without going into detail as you will be describing coping modes in section 9.4.

Section 9.3 Dysfunctional Parent modes

Dysfunctional Parent modes are internalizations of experiences of parent or other significant authority figures who failed to attend appropriately to the needs of the child. Positive Healthy Parent behaviors also become internalized and contribute to healthy and adaptive development. Such positive attributes include being unconditionally nurturing and accepting, being dependable, consistent and capable, being attuned and playful, supporting the development of agency and autonomy appropriate to the child's/adolescent's age, and honoring the child's intrinsic worth independent of achievements and aptitudes (Louis, Wood, and Lockwood, 2020). Initially, Young, Klosko and Weishaar (2003) used the terms Punitive, Demanding and Critical to name specific **Dysfunctional Parent** modes. The ***Guilt-inducing Parent*** mode was recognized by Jacobs et al (2015), and Peled (2016) drew attention to several other **Dysfunctional Parent** modes such as the ***Overanxious Parent*** and the ***Indulgent Parent***. A comprehensive integration was offered by Edwards (2022) from which the table below is drawn.

Type of failure to meet child's needs	Features
Fails to give appropriate structure or guidance	Neglectful; Indulgent; Naïve
Overprotects and interferes with the development of the child's autonomy	Overanxious; Overprotective; Victim or Guilt-Inducing
Fails to attune to the child or breaks connection	Invalidating; Rejecting; Abandoning
Is critical and coercive	Demanding; Punitive; Blaming; Shaming; Coercive/Controlling; Abusive
Is unpredictable	Unstable; Emotionally Volatile; Unpredictable; Terrifying

Parent modes may be distinct, but, often, several different attributes are blended together.

In the table on the case conceptualization form, in the left-hand column, list the main features of **Dysfunctional Parent** modes that you have identified. Then, in the right-hand column, for each feature, give examples of the kind of messages (explicit or implicit) conveyed by the internalized parent. For example:

Punitive	"You are a bad person and deserve to be punished"
Demanding	"Meet my expectations that you behave in specific ways, meet high standards etc."
Overanxious	"The world is dangerous ace and you need to be very careful and stay close to me."

Section 9.4 Maladaptive Coping modes

In this section provide information about the most prominent maladaptive coping modes you have identified. List them in the table. Under a) put the category to which it belongs (surrender, overcompensation etc.). Under b) list the names of the modes. Under c), where relevant, list any schema that **corresponds** to the mode. Do not list schemas which might be associated with the mode, just those that correspond to it directly (e.g. for Self-Aggrandizer - Entitlement/Grandiosity; for Compliant Surrenderer - Subjugation).

Then select **up to three** of these coping modes and describe in detail the client's experience when in the mode, using the table:

a) Give an example of a situation that leads to activation of the mode (or, if relevant, state that it is a default mode.

b) Describe the client's experience and behavior while in the mode.

c) Where you can, identify what the mode is coping with in the Child, or indicate that this is still unclear.

d) Describe the perceived value of this coping mode for the client.

e) Describe any problematic consequences of coping in this manner.

Although other coping modes may be activated by the trigger situation, don't go into them here. In the next section you will be asked to look at sequences of modes activated in a specific situation.

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. 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 situations in the client's life that show how the 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 (where the main focus was on a single coping mode).

Describe the trigger situation and then, in each of the rows below, provide the following information:

a) The Child and Parent modes that are activated. Usually, a child mode is activated in conjunction with a Parent mode. For example, when there is a Shamed Child, there is also a Punitive or Shaming Parent. Sometimes the client seems to go straight into a coping mode, and these Child and Parent modes may not be visible at all. However, they are present in the background in that the coping mode has been activated to cope with them.
b) Name the coping modes involved in the sequence, and for each mode, give a short description of the client's behavior in that mode.
c) Describe the full mode sequence in order. Just give the names of the modes and other relevant information such as the impact on other people. Do not go into detail about specific client behaviors. For example: Abused Child and Punitive Parent – Paranoid Overcontroller – Others feel attacked and withdraw – Abandoned Child – Angry Child – Self-Pity Victim – Avoidant Protector (withdraws and is alone).
d) Where relevant, describe the impact on the situation, and particularly on other people, of the client's switching into the different modes. For example, in the sequence above, you can elaborate on how people react to the client's Paranoid Overcontroller: "they feel attacked, they feel cautious, and they usually withdrew emotionally or physically or, at times they express anger and this leads to a heated conflict."
e) Explain how this mode sequence results in the perpetuation of the underlying maladaptive schema patterns by preventing emotional processing in the Child and/or by preventing the client from learning how to find ways of meeting important core needs in the present.

11. The Therapy Relationship

11.1 Therapist's Personal Reactions to the Client

Each client can elicit a specific and unique set of reactions from the therapist. Some of these reactions are healthy and facilitative of the therapy relationship and process, while others are problematic, as the therapist switches into a coping mode that is problematic for the therapy. Developing self-awareness and understanding of these reactions can, therefore, help the therapist to stay in the Healthy Adult, and avoid flipping into coping modes. It can also be a source of valuable information about the client's schemas and modes.

Describe your personal reactions to the 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.

11.2 Collaboration on Therapy Objectives and Tasks

Overview: Definition of therapy collaboration

Therapy Collaboration is defined as the quality of the alliance between the therapist and client, with a particular focus on the degree to which both are can agree upon the objectives and tasks of therapy. It also pertains to the way the therapist is able to negotiate with the client on the content and focus of each session, and the client's engagement in the tasks of therapy. This can be measured by interest in the session, engagement with the therapist, consistency in coming to sessions, and participating in the therapy homework.

Consider this example: Therapist and client have been able to agree on objectives that are important to the client, and the client is enthusiastic about reaching these goals. There is an easy dialogue in working out what is best to discuss and explore from session to session, and the client appears willing to explore interpersonal issues. However, the client often misses appointments or needs to change the appointment time. This seems inconsistent with the enthusiasm expressed in session, and with the relatively undemanding circumstances of the client's life. The client completes homework approximately 50% of the time; and the reasons given for not completing homework are often not convincing. In such a case, the collaboration would be rated as 3 on the scale below.

11.2.1 Rating of Collaboration on Objectives and Tasks

Rate the level of Therapy Collaboration *based on your client's behavior in session and outside session.* Consider your client's degree of engagement, participation, adherence to assignments, etc. Use the following 5-point Scale to rate the degree of collaboration:

- **1 = VERY LOW** (e.g., cancels often, devalues the therapy work, shows minimal commitment)
- **2 = LOW** (e.g., inconsistent participation, misses sessions regularly, unfocused)
- **3 = MODERATE** (e.g., hesitant and skeptical some of the time, attends regularly, does some homework)
- **4 = HIGH** (e.g., is engaged and willing to participate and work in therapy)
- **5 = VERY HIGH** (e.g., enthusiastic, focused, responds quickly and positively to the therapy work)

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. For example, you could include an evaluation of the degree to which there is a) a sense of shared understanding, b) agreement on objectives and strategies for change, and c)the capacity to work out and resolve conflicts.

11.2.3 How could the collaborative relationship be improved?

Where collaboration is moderate or low, what changes could you and your client make to improve the degree of collaboration? Focus on the kinds of barriers that make collaboration difficult. These could include

a) chronic misunderstandings;
b) lack of agreement about goals for therapy
c) lack of agreement about what is needed to work towards achieving the goals for therapy;
d) problematic reactions and behaviors in your client such as helplessness and passivity, passive-aggressive behavior, disdainful attitude towards the therapist and therapy, failure to complete homework, missed sessions.
e) problematic reactions and behaviors on your part due to triggering, such as rescuing, scolding, lecturing or trying to appease and placate your client.

Suggest ways in which the problems and obstacles you identify could be addressed.

11.3 Reparenting relationship and bond

Overview: Definition of the reparenting relationship and bond

The reparenting relationship and bond refers to the level, depth and type of attachment and bonding between the therapist and client. It depends on the client's receptivity to limited reparenting in the relationship in response to the therapist's offering to meet the client's core needs (demonstrating such characteristics as warmth, acceptance, non-verbal expressions of caring, validation, and promoting autonomy). When doing emotion-focused work, it includes the client's capacity for vulnerability and for accepting and responding to reparenting of Vulnerable Child or other child modes such as the Angry and Enraged Child.

The therapist needs to describe and assess the client's responses to attempts to offer reparenting that s/he can adapt their reparenting response in future sessions.

Consider this example: The therapist often attempts to validate the pain and suffering the client feels in relation to current concerns. But these attempts are usually met with the client minimizing or denying any need for validation. When the therapist demonstrates empathic understanding of the confusion and uncertainty the client feels regarding their current circumstances, the client usually just stares blankly back at the therapist. This reaction changed recently when the client's eyes sometimes glistened with tears, and the client began to lean forward toward the therapist. The client has been encouraged to call between sessions if they need to talk, especially since a new interpersonal crisis has arisen. The client has made a "check-in" call once, but with apologies for interrupting the therapist's life.

Here, the reparenting bond is currently tentative, and reflects a cautious attachment. It is unclear whether the therapist's behavior during sessions is somehow contributing to the difficulty in creating a more secure reparenting bond.

11.3.1 Rating of the reparenting relationship and bond

Rate the depth of the reparenting relationship and bond based on the client's behaviors and emotional connection, both in sessions and outside of sessions.

Use the following 5-point Rating Scale to evaluate the strength of the reparenting bond. The descriptions below are examples of the kind of client behavior to be found at each level, as evidenced in their verbal as well as non-verbal behavior (e.g., body language, eye-contact):

1. **VERY WEAK, MINIMAL:** For the therapist, the relationship is experienced as very impersonal. the client is mostly detached, and unable to acknowledge or respond to the therapist's interest and care. Or the client routinely has a dismissive or disdainful attitude towards the therapist and the therapy. Or the client may flip between different modes none of which can genuinely connect to the therapist as a person.
2. **WEAK:** For the therapist, the relationship is mostly experienced as rather impersonal. The client is rather detached, with limited capacity to respond to the therapist's interest and care. Or the client may often be abrupt, dismissive or disdainful of the therapist and the therapy. Or the client frequently flips between seeming to be open the therapist as a mentor or parent figure, on occasion, but mostly being detached and/or dismissive or disdainful.
3. **MODERATE:** The client can at times respond to the therapist like a parent-figure, friend, or mentor, and seems to have moments of experiencing the therapist as genuinely caring, and can be vulnerable and trusting with the therapist. However, this is not sustained, and the client often switches into modes that are more detached and disconnected, or, dismissive or disdainful.

4. **STRONG:** The client responds to the therapist like a parent-figure, friend or mentor, and, mostly, experiences the therapist as genuinely caring. The client can usually be vulnerable and trusting with the therapist, both in the relationship itself, and, when doing experiential work, can usually allow the therapist to protect and care for the Vulnerable Child.
5. **VERY STRONG:** The client consistently responds to the therapist like a parent-figure, friend or mentor, and, experiences the therapist as genuinely caring. The client can consistently be vulnerable and trusting with the therapist, both in the relationship itself, and, when doing experiential work, can allow the therapist to protect and care for the Vulnerable Child.

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

Give a description of your client's behaviors with you that are relevant to their openness to receiving reparenting.

Provide details and examples of their behaviors, emotional reactions, and statements in relation to you that serve as indicators of how weak or strong the reparenting bond is.

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 you take to strengthen the bond?

11.4 Other Less Common Factors Impacting on the Therapy Relationship (Optional)

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

12. Therapy Objectives: Progress and Obstacles

Select at least four therapy objectives that are central to the work of therapy with this client. Objectives should be such that you 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, in the rows below:

(a) summarize the modes and schemas to target, making clear how these are related to the specific objective;

(b) describe new Healthy Adult behaviors that are related to the objective;

(c) describe specific interventions you are using and the rationale for your choosing them;

(d) summarize progress made and obstacles encountered in implementing this therapy strategy.

You can briefly refer to additional important objectives in Item 5.

13. Additional Comments or Explanations (Optional)

Here you can add any additional information, or clarify any of your answers above, to help your supervisor or rater better understand your conceptualization of this client, the therapy relationship, and progress in therapy. You can add additional pages if you want to.

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