Combining EMDR and Schema Mode Therapy for Complex Posttraumatic Stress Disorder

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What is Eye Movement Desensitization and Reprocessing?

Eye Movement Desensitization and Reprocessing (EMDR) was developed by Francine Shapiro in 1989 as a method of treatment for Posttraumatic Stress Disorder (PTSD). Over time, researchers and therapists expanded the use of EMDR to include several other mental health diagnoses besides PTSD. It was discovered that not only did EMDR eliminate the impacts of acute memories leading to PTSD, but it also eliminated the negative impacts and irrational self-perceptions caused by nonacute memories and bad experiences in general. This is particularity true with individuals who have a history of repeated abuse or repeated traumatic incidences causing Complex Posttraumatic Stress Disorder (Complex PTSD).

Due to the many complexities found in the assessment and treatment of Complex PTSD, EMDR treatment required added interventions and assessment tools. These tools can be found in Schema Therapy and one of its interventions called "Schema Mode Therapy". This article explains how EMDR and Schema Mode Therapy can be combined for increased speed and effectiveness for treatment of individuals suffering from Complex PTSD.

EMDR and Neurobiology

EMDR is a treatment method used to quickly and effectively eliminate the negative impacts of traumatic memory. EMDR is a neurobiological intervention that makes use of eye movements to facilitate a physiological impact on brain functioning which creates permanent emotional and cognitive change in an individual when thinking about or visualizing a traumatic memory.

Recent studies on brain scans of individuals indicate that traumatic experience and traumatic recall negatively impact brain functioning and that EMDR corrects it. Specifically, during trauma a part of the brain called the amygdala, which controls many of our emotions and is responsible for autonomic responses associated with fear and fear conditioning, becomes over activated and this creates an impasse between itself and the hippocampus. The hippocampus plays an important role in the consolidation of information from short term memory to long term memory and spatial memory which is responsible for recording information about one's environment and spatial orientation.

It is recognized that this impasse between the hippocampus and the amygdala creates symptoms found in generalized anxiety, panic attacks and posttraumatic

stress disorder. During EMDR, this impasse is corrected as eye movements will both enlarge and activate the hippocampus so it can receive the overwhelming amount of information from the amygdala and then sort it. The hippocampus then completes the proper brain processing by sending information to the anterior cingulate cortex, which is involved in aspects such as attention, decision making, reward anticipation, ethics, morality, impulse control and emotion. The impact of opening this impasse and restoring proper brain functioning means that a negative memory, once too overwhelming to manage, is put into the proper context of time and space, has affective and cognitive aspects of the memory merged, is viewed with more rational thought, reason and control and exists in a clear distinction between the past and the present.

EMDR and the Two Primary Positive Treatment Reactions

During EMDR treatment, which is administered by a psychotherapist, a client responds to the neurobiological process described above and experiences two primary reactions to a traumatic memory. First, there is a distancing from the memory that includes an elimination of the negative emotional reactions related to the trauma. Second, the client experiences an increased level of rational perception related to the memory. This increased rational thinking is called Adaptive Information Processing (AIP). AIP is the result of successful EMDR reprocessing and allows the client to hold a more rational view of personal safety, personal responsibility and personal choice while visualizing or discussing a traumatic memory. AIP also allows the client to hold an accurate positive self-perception or cognition while visualizing the trauma. This assists the client in problem solving how he or she would react, or prefer to react, differently in a similar situation. Repeating the EMDR procedure over a series of planned interventions targeting traumatic memories relieves the person of the negative impacts the memories have created. Due to its neurobiological quality, the changes from successful EMDR reprocessing are permanent and generate dramatic symptom reduction across the spectrum of most all mental health diagnosis.

What Is Schema Therapy?

Schema Therapy is a branch of Cognitive Therapy that was developed by Jeffrey Young PhD and includes several different psychotherapeutic interventions including Behavioral, Gestalt, Psychoanalytic and Relational Therapies. Schema Therapy argues that if individuals are abused or neglected as children, they may develop "maladaptive schemas". This is particularity true with individuals who have a history of repeated abuse or repeated traumatic incidences causing Complex Posttraumatic Stress Disorder. Maladaptive schemas (known as schemas) can be defined as self-defeating emotional and cognitive patterns that begin in early childhood and continue throughout life. The goal of Schema Therapy is to eliminate the schema(s) by recognizing and challenging it and replacing it with more effective behaviors. One of the ways to accomplish this goal is through Schema Mode Work.

Schema Modes

Schema modes can be defined as moment to moment emotional states and their related behaviors that all individuals use to manage life events. Often a life event will trigger a schema and then the person will switch their behavior and thought process to a maladaptive mode. Schema modes can be adaptive or maladaptive and the goal of Shema Mode Therapy is to recognize maladaptive modes and replace them with adaptive modes.

Modes are measured by both their level of rigidity and intensity. For people who are responding to life events in a healthy way, their responses tend to be flexible and not ridged. The flexibility between changing modes during a healthy reaction is spontaneous and the individual can switch from one mode to the next as well as easily recall their thoughts, feelings and actions when shifting from one mode to the next.

Also, an adaptive reaction to a life event consists of a reasonable level of intensity. While some events in life are extreme and have major emotionally reactions, others are not extreme. The quality of healthy mode reactivity is rational and parallels the intensity of the event.

Unhealthy behavior is more ridged in quality. For example, one might quickly switch from a healthy adult mode to a more childlike mode and the intensity of the child mode will take over the person's thinking and behavior. Thus, the person appears to lose control over their behavior as well as the stability of identity. These sudden mode switches impact the sense of cognitive, emotive and behavioral maintenance and the overwhelm of the mode causes difficulty recalling healthy mode experiences. This is shown in its most extreme forms during states of dissociation which schema therapists would describe as a process of extreme mode switching and reactivity.

Also, an unhealthy reaction to a negative life event consists of an unreasonable level of reactivity to that event. Thus, if a person switches to an unhealthy mode they might appear to overreact to situations that are minor, or they might appear to have very little or no reaction to life events that are overwhelming or critical.

Schema Mode Categories and the Nine Schema Modes

Schema Therapy defines nine schema modes as the basis for mode behavior. In a sense, all these modes are universal. In other words, all people tend to embrace each mode. Again, the concerns have to do with the person's level of rigidity and/or intensity when in the mode. The nine schema modes fall into three categories. Below is a description of each category followed by a description of each mode within that category. A description of the healthy adult mode is included.

Child Modes – Child modes are characterized by childlike feelings, thoughts and behaviors. The impact of a child mode can be mild yet in extreme forms the person might give the mode an identity. This, according to Schema Therapy, is the foundation for the switching and reactivity found in Dissociative Identity Disorder.

1. The Vulnerable Child Mode – The individual in a vulnerable child mode will experience dysphoric, anxious and sad feelings when triggered by a life event or memory. Other emotions might include loneliness, isolation, overwhelm, self-questioning, neediness, helplessness, hopeless, abandonment, fragility, weakness and oppression. The behavior of the vulnerable child depends on which dysfunctional coping mode they use to manage their reactions.

2. The Angry Child Mode – The individual in an angry child mode is fueled by feelings of victimization and bitterness which then leads to pessimism, jealousy and rage. The individual often feels unsupported and may have urges to yell, scream, throw or break things or injure themselves or others. Often a trigger for the switch to an angry child mode is the sense that one's needs are not being met.

3.The Impulsive or Undisciplined Child Mode - The individual in an impulsive or undisciplined mode acts on their desires of "at the moment" needs. The individual generally acts impulsively and in a selfish and/or uncontrolled manner. The person has a desire to get his or her own way and has difficulty delaying short-term gratification. Emotionally the person feels anger, rage, frustration and impatience when these desires or impulses are not met. The person generally appears to be "spoiled".

4. The Happy Child Mode – The individual in the happy child mode feels at peace because their core emotional needs are being met. Generally, the person experiences love, validation, safety and connection. The person thinks they are special, lovable, important and strong.

Dysfunctional Coping Modes – Dysfunctional coping modes are used to prevent emotional distress but end up reinforcing or perpetuating the schema. These coping modes parallel the core emotional, cognitive and physical reactivity seen in fight, flight or freeze behaviors referred to in schema language as overcompensation, avoidance and surrender, respectively.

1.The Overcompensator Mode – The individual in the overcompensator mode will adopt a coping style to counteract feelings of defectiveness or feelings related to not getting their emotional needs met. The individual appears inordinately grandiose, aggressive, dominant, competitive, arrogant, haughty, condescending, devaluing, controlling, rebellious, manipulative, exploitative, attention-seeking and status-seeking. The individual in this mode perpetuates their schema patterns since they actively deny the schema's existence.

2. The Detached Protector Mode - The individual in the detached projector mode cuts themself off from their own needs and feelings and presents with an overall appearance of avoidance. The person will detach emotionally from others and reject outside assistance. The person appears to be withdrawn, distracted, disconnected, depersonalized, empty, bored or aloof. The individual may

compulsively and excessively pursue distracting, self-soothing, or self-stimulating activities. The individual in this mode perpetuates their schema patterns since they cut themselves off from problem recognition.

3. The Compliant Surrenderer Mode – The individual in the compliant surrenderer mode typically acts in a passive, submissive, approval-seeking or self-deprecating way to avoid conflict or rejection. Individuals in this mode will tolerate abuse and mistreatment and will not express their own needs. The individual in this mode perpetuates their schema patterns since they are avoiding effective problem-solving.

Dysfunctional Parent Modes – Dysfunctional parent modes are internalizations of critical, demanding, or harsh parental voices. When someone is in this set of modes they will take on and own the messages taught to them through abusive behavior and will act as if the message is real and appropriate. Although this is described as a "parent" mode, the negative abuse messages can come from anybody including teachers, religious leaders, siblings, relatives or peers.

1. The Punitive Parent Mode – The individual in the punitive parent mode generally believes that they deserve punishment and blame. Often the person will be self-abusive shown by self-mutilation, anorexic behavior, bulimic behavior, self-sabotage, self-loathing, self-blame, self-criticism and suicidal thoughts and behaviors. The individual will present with a tone that is harsh, unforgiving and critical. Relative to norms and rules there is a preoccupation with the style of rule enforcement rather than rule appropriateness.

2. The Demanding Mode – The individual in the demanding parent mode is preoccupied with perfectionism, achievement, order, status and efficiency. The individual will appear irritated, anxious, demanding and/or emotionless. There is a tendency for the person to devalue both spontaneity and emotional expression. Relative to norms and rules there is an emphasis on the act of meeting high standards rather than on the style of implementation or the general effectiveness of meeting a particular purpose.

Healthy Adult

The Healthy Adult Mode – The individual in the healthy adult mode presents as being comfortable in their decisions, problem-solving, impulses, ambitions, limitations and relationships. The individual acts in a way that is responsible, thoughtful, participatory and self-nurturing. Relationally the person can maintain presence without a preoccupation for the past or future. Schema Therapy concentrates on the role of the adult mode to use its resources as a method of self-parenting when other modes have taken control.

Schema Mode Treatment

Schema Therapy emphasizes the role of five primary steps for useful mode work. Generally, these steps are taken within the context of treatment, but benefits can also come by doing the exercises alone. The end goal of these initial five exercises is to be able to do schema problem solving as defined in the next section. List your answers.

1. Schema Mode Identification – The first step is schema mode identification. This involves learning about the different schema modes and identifying the most common modes used including both negative and positive modes. One can read the schema mode descriptions and with an understanding of the characteristics, begin to list the modes that are most often used.

2. Origin and Adaptive Use – The second step is recognizing the schema mode's origin and adaptive use. The origin of the schema mode typically comes from the family of origin, usually a parent. However, it could also include other significant figures from youth. Following this, begin to think about how it was helpful or adaptive for use as a child in order to survive but as an adult, is ineffective.

3. Triggers Identification – The third step is trigger identification and involves the recognition of the most common life events that initiates mode switches. It can be helpful to think about sudden shifts in mood or an awareness of others' change in reaction to behavior.

4. Mode Advantages and Disadvantages – The fourth step is recognizing the advantages and disadvantages of the mode. This can be done by putting oneself at a distance from the behaviors and evaluating its negative and positive impacts on social, emotional and physical being as well as its general impacts on life. The recognition of mode advantages and disadvantages is an important part of the process of self-parenting.

5. Self-Parenting – The fifth step is self-parenting. Generally, this involves the processes of seeing and adapting the use of both the Happy Child Mode and the Healthy Adult Mode. Change occurs as one uses these healthy modes to nurture or redirect unhealthy modes. This can be done by the imagery of changed behavior or the imagery of seeing oneself in a healthy mode providing safety or direction to an unhealthy mode.

Schema Mode Problem Solving

With the initial exercises completed one is a better position to coordinate and use the learning on a day to day basis. The goal is to use the understandings and growing awareness from the previous exercises and apply them to daily relational and emotional challenges perpetuated by the modes(s).

Completing the framework sentence below will allow for gradual change and the elimination of unhealthy schema modes. The goal is to get to the point of being able to do the exercise automatically in real life settings.

Use the framework sentence below to talk, write or think through a challenging life situation.

I feel **(emotion)** in **(this part of my body)** and the emotion was caused by **(causal event**). This event has triggered my **(mode)** which was taught to me by **(family of origin influence)**. This mode reaction has caused me to exaggerate or overreact by **(behavior)**. The mode may have been helpful when I was **(age or situation)** but today it is ineffective because of **(disadvantages)**. Although my schema causes me to believe that I am **(negative self-belief)** I am **(rational positive self-belief)** as evidenced by **(supporting evidence)**. Although I would like to do **(negative behavior)** instead I will do **(positive behavior)**.

Combining EMDR and Schema Mode Therapy for Complex Posttraumatic Stress Disorder

Both EMDR and Schema Mode Therapy are highly effective treatment methods for Complex PTSD. Combining these methods leads to a faster and more effective level of change by using their relative strengths. EMDR is fast and highly effective in eliminating the negative impacts of negative memories. Additionally, the changes are permanent. However, individuals with Complex PTSD present with complicated histories and a set of symptoms that do not allow the therapist using the EMDR Protocol to accurately assess negative contributing memories leading to Complex PTSD symptoms. Schema Therapy provides a plausible explanation for the development of Complex PTSD since it is based on understanding the impacts of unmet childhood needs and its related negative experience and memory. Schema Mode Therapy explains the related patterned behaviors that are a result of these schema developments. The EMDR therapist can use this understanding of schema behavioral reaction to better target interfering memories leading to those behaviors.

Below is a list of the eight treatment steps that are needed to safely and effectively combine EMDR and Schema Mode Therapy.

1. Use EMDR to reprocesses the memories creating PTSD symptoms first – Complex PTSD can consist of both major traumatic memories as well as memories of repetitive nonacute occurrences. Following the initial assessment, it should be determined if the client has symptoms of PTSD. If it is the case, those memories leading to PTDS should be reprocessed first using EMDR. This will allow for the greatest amount of relief for the client in the fastest way. Also, it will allow in better functioning in and out of sessions and more ego strength to manage the Mode Therapy treatment process.

2. Use EMDR to target memories leading to schema development. – The impacts of repetitive abuse in a relationship or in childhood will have a profound negative and confusing impact on a person's cognitive, social, and emotional life. After a schema

assessment is completed, the client and therapist can evaluate the origins of the schema(s) and create an EMDR target memory list which represents the negative, nonacute events of repetitive trauma and loss leading to schema development. Completing this process will decrease or eliminate the schema and decrease the need of schema mode behaviors.

3. Use EMDR to target the origins of the modes. - The origin of a schema mode typically comes from the family of origin, usually a parent. However, it could also include other significant figures from youth such as peers, siblings, teachers, religious leaders or extended family members. The therapist should identify with the client the people who are a part of the schema mode's origin and then create an EMDR target list accordingly. Reprocessing these memories should decrease the susceptibility to and intensity of mode shifts

4. Use EMDR to target triggers leading to mode switching - Triggers are specific life events or memories leading to a stress reaction and the internal need to switch to a maladaptive mode. The client and therapist should create a list of triggers that occur in and out of sessions, treat each trigger like a target EMDR memory and apply the standard EMDR protocol. This should assist the client in being less reactive in similar future situations.

5. Use EMDR to target the disadvantages of mode behavior - After a client has put themself at a distance from the mode behaviors and evaluated its negative and positive impacts, the therapist and client should treat the disadvantages as a negative memory and apply the standard EMDR protocol to this memory. This will allow the client to distance themselves from the negative emotional consequences of the mode behavior and to envision a changed narrative by integrating the positive cognition during the EMDR phase five installation procedure. The process parallels the schema mode intervention of reparenting.

6. Use EMDR to target self-abusive and aggressive behaviors by using the punitive parent mode – Outside of sessions the client should track times of self-abuse and aggression. These events can be discussed in treatment and reframed as a punitive parent mode behavior. The client and therapist can then evaluate the origin of the punitive mode (i.e. parent, sibling, teacher…) and create an EMDR target memory related to the origin. This process should allow for emotional distance from the origin, increased rational perspective regarding esteem and decrease mode potency.

7. Use known dysfunctional coping modes as a guide for EMDR targets. - Dysfunctional coping modes are used to prevent emotional distress but end up reinforcing or perpetuating the schema. These coping modes parallel the core emotional, cognitive and physical reactivity seen in fight, flight or freeze behaviors referred to in schema language as overcompensation, detached protector and compliant surrenderer, respectively. As a client recognizes their coping modes, they should identify the event leading to the mode behavior. This event should be listed as an EMDR target and reprocessed. This should assist the client in creating more effective methods of change that are less defensive.

8. Evaluate if the positive cognitions of EMDR represent a description of the healthy parent mode - After an EMDR target list is created or completed, the therapist and client should evaluate if the positive cognitions used in the EMDR phase five installation procedure represent the quality of the Healthy Adult Mode. If they do not, then these qualities should be listed and used in other Schema Mode exercises or EMDR memories. It is likely that the cognitions and healthy mode will be much the same since the client's stated desire for cognitive change against the imagery of impaired self-perceptions seen in the EMDR procedure represents a clear illustration of healthy functioning. However, the exercise of healthy adult imagery may lend to the client another method of internal resources leading to self-healing.

Resources

Eye Movement Desensitization and Reprocessing: Basic Principles, Protocols and Procedures by Francine Shapiro PhD (2001)

EMDR as an Integrative Psychotherapy Approach: Experts from Diverse Orientations Explore the Paradigm Prism Edited by Francine Shapiro PhD (2002)

Getting Past Your Past: Take Control of Your Life with Self Help Techniques from EMDR Therapy by Francine Shapiro PhD (2012)

Schema Therapy – A Practitioner's Guide by Jeffrey Young PhD, Janet Klosko PhD and Marjorie Weishaar PhD (2003)

Reinventing Your Life by Jeffrey Young PhD and Janet Klosko PhD (1993)

Schema Therapy by Eshkol Rafaeli, David Bernstein and Jeffrey Young (2011)

Negative Thinking Patterns: A Schema Therapy Self – Help and Support Book by Gitta Jacob, Hannie Van Genderen and Laura Seebauer

Cognitive Therapy – Basic and Beyond by Judith Beck (1995)

Cognitive Therapy for Challenging Problems by Judith Beck (2005)

Cognitive Therapy for Personality Disorders – A Schema Focused Approach by Jeffry Young (1999)

Cognitive Therapy of Personality Disorders by Aaron Beck, Arthur Freeman and Denise Davis (2004)

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