The Schema Therapy Clinician’s Guide:
Exercises from the book

Group Exercise 1: The Group Connection Exercise

“We are going to do an exercise now with this ball of yarn. First I am going to wrap it twice around my hand so that I have a firm connection and then I am going to throw it to one of you. When I do, I will say my name and my role in the program. The other therapist(s – plural as needed) will all do the same thing. I would like each of you to tell us your name and where you are from. Wrap the yarn around your hand, not too tightly, and when you are ready to throw the ball, make eye contact with the person you are throwing to and let it go. That will help their chance of catching it. The last person who will be thrown to is T2.”

Patients and therapists toss the ball of yarn back and forth, each person connecting to the yarn by wrapping it around their hand so that a web of connections is constructed within the group circle. After all are connected once with the yarn, we have them make another connection around the circle from person to person. Then we comment on the added connections. [Make sure that you have a large enough ball to include everyone with the two connections.]

“Now we are going to make a second connection. Wrap the yarn around your hand again and then pass it to the person on your right and say your name one more time. When it gets to T2, he/she will throw it across to me. [After this is accomplished] Be aware of all the connections we have right now, feel the strength...”
of them (the therapists playfully tug their various connections, making eye contact with group members and smiling). [In the rare occurrence of the yarn breaking – quickly tie a knot to bring the ends together and say “Fortunately, even if a connection breaks briefly here it can be restored.”] Take a snapshot of our connection matrix in your mind’s eye that you can later bring to mind to remember your place in the group. Look at all the connections and see how we are all linked together. Every one of you is important to the group. You matter and are needed to make our group strong and whole.

The next part of the exercise starts with the therapist and asks what each person wants one of their connections to represent or contribute to the group. T2 [whichever of the two therapists for that group who has not been leading so far] pulls on one of the strings attaching her to the group and says:

"I want this string to represent trust. (Then he/she looks to the right-hand patient.) What do you want your connection to the group to represent? (This is repeated until all have had a turn. After that, the therapist again points to the connections.) Let’s feel the strength of our connections again (playful tugging). I want you to pay close attention to what happens if I do this (T1 lets go of the yarn). Could you feel it? What if one more lets go? How was that, what did it do to our connection? (Leave time for some responses.) That is what happens when one of us is not here – a connection is lost. [After brief discussion] Let’s restore our connection now. How does it feel when we do that? [Despite patients having just met each other, they usually respond to the connection being dropped. If no one verbalizes this, the therapist can model a reaction of some loss or difference in energy or even temperature – less warm.] We aren’t going to keep this in place all the time, but when we want to really feel our connection reinforced we can bring it out. For now, let’s lay it down on the floor in front of us. We do have some ways to keep your awareness of our connection in the group."
Therapist Tip

This is usually a positive exercise for patients. If a problem arises, try to deal with it in terms of the ST model. For example, if someone feels uncomfortable with the connection, don’t force it, rather support them connecting at whatever level they can. That may mean sitting in the group with the connecting yarn attached to their chair, not their body, or if they do not feel safe connecting with the group as a whole, but have therapists or patients they feel safe with, let them use a piece of yarn to connect with that person. Be creative, as all you are trying to accomplish is the beginning of connection.
Group Exercise 2: The Group Safety-Bubble

The first safety image that we present to patients is a simple image we have found to work with a wide variety of patients. This is an imagery exercise in which we put a huge “magical safety-bubble” around the whole group. This fits with the developmental approach of ST which suggests that safety and protection initially need to come from the therapists.

Sample Therapist Script

Either close your eyes or look down and take a few deep, slow breaths and just feel any tension leave your body and mind. Imagine that we are surrounded by a huge transparent bubble large enough for all of us to fit inside comfortably and filling up the group space. It is a beautiful bubble with all of the colors of the rainbow. You notice that it even has a wonderful fragrance to it. It is a magic bubble that can protects us from anything outside of it. No unhealthy parent voices or critics can get through its walls. It is unbreakable – no one can get in, but you can walk in and out of it if you need to or take it with you as you move. Bring into the bubble any comfort objects that you like. You can take into the bubble anything you want that will be soothing to you and help you feel strong and safe. No one can bring anything in that could be used for harm. The bubble symbolizes the safe cocoon we have here in the space of the group. T2 and I will not let you be harmed here. We will protect you and “have your back.” All of you are valuable to us and we want you to know that here you are safe. Just take in the warmth, safety, and connections of the bubble. Stay focused on these feelings for a few minutes and keep your breathing deep and slow. When we come back to having our eyes open, let the bubble stay protectively around us. If you feel the need for your own bubble, imagine that you have a smaller one that is just around you. It is even one that you will be able to take home with you. We will all connect with it again before you leave today.
Welcome Group Handout 2: The Bubble-Safety Technique

Uses of the Bubble Technique Outside of Group

Bubble technique 1

Imagine a bubble large enough for you to fit inside. Imagine it in any color you like and as beautiful as you want to make it. It is a magic bubble because you can walk in and out of it without breaking it. You can take into the bubble anything you want that will be soothing to you and help you feel strong and safe. You may let other people in or you may choose to be by yourself. One thing you may not take in is anything harmful to you or unhealthy. When you are in your bubble, you won't need those things because you feel so safe and relaxed there.

After you are able to imagine your bubble and have gone into it with whatever you want, imagine the bubble floating away to wherever you want it to go. You may want to close your eyes and maybe even listen to peaceful music as you float away in your safe bubble. No unhealthy parent voices or critics can get through the magic bubble. You may stay in your bubble for as
long as you want to or need to. It is best to stay there until you think you can come out and be safe. After you come out of your bubble, relax for a few minutes before you do anything else.

**Bubble technique 2**

For this technique, imagine a bubble, but this time do not put yourself or your belongings into it. Instead, put anything that is bothering you into the bubble. For example, you may want to put into it the voices that bother you or you may want to put in your urge to harm yourself. The point is to put negative things into it. Once you have put in everything you want to get rid of, seal up the bubble and send it away. Close your eyes and imagine the bubble floating high and far away from you until you can no longer see it. When you feel safe from the negative things, open your eyes and slowly resume your day.

Practice both of these techniques every day and write in your journal about your experiences with using this imagery technique.

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**Therapist Tip**

When it comes to imagery or other experiential exercises, patients may object to participating, saying it is “silly” or even “bullshit” and refusing to try it. We avoid ending up in a battle over this. We may say: “I am so glad that you spoke up to tell me you felt it is silly. That took courage. Good for you. I can see how you would think it sounds silly before trying it. Let’s see if you feel that same way after you try it. We have found it to help many people.” More often than not, they then try it.

Another complaint is “I cannot possibly use a bubble.” So, come up with something that will be appealing: “OK, what about a brand new car, a Hummer, with all the safety measures available?” It could be a fortress or whatever you can think of or the patient offers. It is important not to ignore their objections but to work with them and be flexible. We “choose our battles” and usually limit them to situations that are dangerous for them or others. Arguing with them usually triggers their Angry Child Mode or a Maladaptive Coping Mode that will make it even more difficult to
reach them. Another alternative is to suggest an individual safety-bubble – same image, but a separate bubble of their own. It can have some kind of connection to the group and the person in the individual bubble is welcome to come in when they want to.

On rare occasions we will have a patient who will not try anything. Here is an example of what we say: “OK, I will respect that today, but I will ask you on another day to respect me and try the exercise. Is that a deal?” or the approach of “Good that you are taking care of yourself. Would a pillow or blanket help you feel safe enough while we try the exercise?”

Usually they take the soothing object and you can incorporate that and them into the imagery. For example, “So we are all in this protective bubble together and we can see Jean over there with the comfort blanket wrapped around her, looking peaceful and calm.” You can pull her into the bubble in gradual steps. For example, have her come closer in imagery and reach out to take her hand from the safety bubble or whatever creative thought that comes to you. If you keep trying, stop at two ideas and let her safely be in the room. She may not be able to join at first and as long as that is acknowledged, it does not have to be such a big deal.
Group Exercise 1: MCM 1 – the Experiential Focusing Exercise

In this first EMW session we begin with an exercise that can increase patients' awareness of any sensation, thought, or feeling they have while completing a short walk toward a peer. This exercise often triggers a person's default Maladaptive Coping Mode (MCM) as it is an unstructured exercise that focuses attention on a relative stranger. We don't tell patients any of this as we do not want to influence whatever their experience may be. (Use the Experiential Focusing Exercise Worksheet (EMW 1-MCM1) for patients to record their observations.)

Sample Therapist Script: Experiential Focusing Exercise

Hello, I am glad that you are all here and I am happy to see you. As you know, this is the Experiential Mode Work Group and our focus today is on the MCM. We will be doing two different therapy exercises today. The first one focuses on your awareness and the second is a mode role-play in which all of us will play the various modes. In the last part of the session we will work on developing a safe-place image that you will eventually be able to use as an alternative to the MCMs. (Therapist name T2) and I will show you how it goes. I will give him/her the same instructions I will give you. “OK, T2, we have done this before – just take a place about 12 feet away from me. I would like you to take slow steps toward me and at each step stop briefly and just note to yourself any physical sensation, thought, or feeling that you are aware of. Don't tell me what you are noticing, but I will want you to write it down after we finish. I will not move. I would like you to stop when you are about three feet away from me – about right here (point to the spot). Now you can start.

T2 goes through the exercise to demonstrate the task. Therapists should try the exercise ahead of time to experience what your patients will. Remember to point out the three-foot point as some patients will walk right into you otherwise.
Sample Therapist Script

Are there any questions before we start? So please pair up now. You will take turns being the one who walks and the one who is stationary. The person who is stationary also should observe his/her sensations, thoughts, and feelings at each step the other takes toward him/her. After one of you has walked, stop, and each of you write down your observations. Then reverse the walker–stationary roles and do it once again.

This part of the exercise takes about 15 minutes. If you notice people taking a lot of time with the writing part, you can give them a “minute warning.” Patients do not usually take a lot of time for either the walking part or the writing. After all pairs have finished, call the group back together for discussion.

Were there any surprises for people? What sorts of experiences were you aware of? Which role did you like better – walking or stationary? Did anyone notice a mode pop up during the exercise? Sometimes an unstructured situation like this and a new person trigger one of the modes and help us learn about the mode in the safe setting of the group. [After a pause for discussion] Good job everyone. Many of the exercises we do in the Experiential Mode Work sessions will be something like this – exercises that give us different kinds of experiences to be able to learn about our own modes and the needs that are underneath them. Any questions?
The experiential focusing exercise takes about 30 minutes.

**Experiential Mode Work Exercise 1 – MCM: Experiential Focusing Exercise**

Mark each step you took when you walked and record any **sensation, thought or feeling** you were aware of. Do the same for each of the other person’s steps when they walked toward you.

- **Point you walked from**
- **Point where you stood**
- **Other person stood here**
- **Other person walked from here**
Group Exercise 2: MCM 1 – the Mode Role-Play

The next exercise, the mode role-play, demonstrates the origin of the Maladaptive Coping Modes and how they function in the present in an experiential way. Patients and therapists play the roles of modes, thus having both an experience of the mode they play and how it feels to interact with the other modes. This is an experiential version of exercises like pro-and-con lists as participants experience the positive and negative effects of being in various modes themselves. You may want to change which therapist takes the lead in the next exercise. Both will have significant roles as the role-play develops. There are diagrams in the therapist notes that can also be used as visual aids in the discussion after the role-play.

Sample Therapist Script

“In this next exercise we are going to do a role-play in which all of us take on the roles of the different modes to demonstrate and experience how they function. Before we can start we need to have scripts for the various modes to use. You were given the assignment to write down your ideas of what the various modes might say. Let’s look at those and T2 will write the scripts down on the white board (or flip chart).

[Refer to Experiential Mode Work Assignments 1 and 7: MCM 1 and 2 (EMW 1&7-MCM1&2) for mode scripts. Patients should be given this assignment before this session, for example, in one of the ST Education groups.]

Experiential Mode Work Assignments 1 and 7 – MCM 1 and 2: Scripts for the Schema Modes

Write down examples of what you think each mode would say.

| Avoidant Coping Modes |  |
| Overcompensating Coping Modes |
| Compliant Surrenderer |
| Vulnerable Child |
| Angry Child |
| Punitive Parent |
Gather script lines for each mode from the patients and write them on a whiteboard or flip chart. This allows you to gently correct any errors in their understanding of the modes and gives them scripts to use when they are playing the modes. Start with the Maladaptive Coping Modes (MCM). Choose two from those represented in your patient group. Don’t get too complicated – basically Avoidant Protector, Compliant Surrenderer, Overcompensator. T1 plays the Healthy Adult Mode (HAM) and directs the action. This makes the point that the HAM is actually in charge of the modes’ actions. T2 plays the Good Parent (GP) who is trying to reach the Vulnerable Child Mode (VCM) to protect, reassure, and soothe him/her.
At first, ask for volunteers for the roles. Begin with the more difficult roles – the VCM, PPM, MCM. This ensures that you will not be left with the most difficult role still to be assigned and the patient who is last to volunteer or does not volunteer at all. If a patient volunteers for a role that we think might be too much for them to handle, we subtly veto it. Saying something like – “Gee, Sara, would you play the coping mode instead this time as you have become really aware of that mode for you and I think that would work out well for what we are doing.” The role to avoid having a patient who is already in the Vulnerable Child Mode play is the VCM, as it is too stressful for an early session. Typically, patients will volunteer for roles they feel able to play without huge difficulty. If too much distress is triggered, you can stop the action and do something to help reduce the distress. We have not found this to be a difficult exercise for patients, rather quite illuminating of the modes and helpful to their understanding of the ST model. It can also have fun elements.

The MCMs are selected to be representative of those predominant in your group. We give the PPM actors a mask of some kind so that they do not come to be seen as their role. Patients in the PPM roles do not usually report difficulty playing them as they are familiar to them. They do sometimes report it being painful when they see the reaction of the VCM. This is an experience we want them to have in order to build compassion for the VCM. If a patient protests that they don’t want to take a role, you can first ask them if they will be one of the helpers. If they still decline, you can ask them to take the role of an observer and pay attention to how the modes interact and the outcome, or even to rate your job in the HAM role. When that is the only role a patient will take, we substitute that for the HAM in training. Whenever possible, we want everyone to have some role, however small, as we want them to stay connected.

Sample Therapist Script

I’m going to play the Healthy Adult Mode. This mode is the director of action and all the other modes must follow my instructions. T2 will take the role of the “Good Parent” and he/she will have the task of reaching the Vulnerable Child Mode with some of the statements we came up with as the script for that mode. Now we need volunteers for the other roles – we will need two to play the MCM modes, a VCM, an ACM, a HAM in training, and a GP in training.
OK, so let’s have a volunteer for the Avoidant Protector and the Overcompensator. Remember, your original job was to protect the VCM from the PPM. So, you will do that using the script we developed. We need two of you to play the PPM and use that script. We are going to give you masks to use for the PPM roles as we don’t want anyone to confuse you personally with that negative role. Who feels able to take the VCM role today? The VCM feels whatever feelings are present. Alright, thank you. And the Angry Child Mode (ACM)? The ACM tries to get attention paid to the VCM need, but does it in a way that is too extreme and gets him/her into trouble. Great. Now we just need a HAM in training to shadow me and a GP in training to shadow T2. You (HAM in training) can borrow some strength from me as needed to set limits on the PPMs. You (GP in training) will shadow T2 and model his/her actions. OK then, let’s put you all in your places. The VCM sits over here with the ACM next to you. The DPM and AP will sit in front of you, but facing away from you as they are focused on the PPMs. Let’s put the PPMs over here about 10 feet away. T2 as GP and the GP in training will sit next to each other about as far away as the PPM. Now each of you in training stay next to your model.

Figure 4.1 Mode role-play of schema modes in action. Scene 1: This is how modes develop and how they function now
Let the ensuing chaos go on for a few minutes and during that time as
the director encourage the ACM to get louder, the PPMs also, and
whatever other coaching is needed from you. Then stop the action
and discuss what happened.

Now, remember that the HAM, me, is like a movie director.
When I give a direction or stop the action you must follow my
directions. That is also the job description for the HAM.
(Figure 4.1 presents Scene 1 and shows how modes develop
and how they function now.)

The first thing we will do is a demonstration of what these
modes were like in your childhood. That means that at the
count of 3, I want each of you to be in role and say your script
lines from the board, adding other statements in role if
you like. 1, 2, 3 – go.

Let the ensuing chaos go on for a few minutes and during that time as
the director encourage the ACM to get louder, the PPMs also, and
whatever other coaching is needed from you. Then stop the action
and discuss what happened.

OK, now everyone stop. Just take a breath. Let's talk about what
happened. We will start with the VCM – was your need taken
care of? Were you protected? ACM – were you heard? MCM –
did you hear what the VCM said – he/she was not protected?
That was your job, but it seems that you failed at it. Did you
even hear the VCM? Were you aware of his/her need? PPM –
do you think you were effective? GP – were you able to reach the
VCM or ACM? So what we just saw demonstrates how the
modes came to be and how they function now.

However, as the HAM, there is a correction I need to make
before we try this out again. The PPMs are way too close as they
are not physically present anymore, they belong back in the
past, so I am going to move them out of here [take PPM actors
to a far corner of the room]. Your voices have become much
lower now. I am going to leave my HAM in training here to
make sure that you stay in the past. [Leave that patient near
the PPM, but facing the VCM.] Now let’s see what happens
with the PPMs placed where they belong. I want everyone else
to stay where they are and say your lines again. [Let this go on
for a few minutes then stop it.] (Figure 4.2 provides a diagram
of step 2.)

OK, what happened that time? It wasn’t a whole lot different,
was it? So the PPM is gone, but the MCM are still facing toward
them and focused on them. Now they are just keeping the T2
GP from reaching the VCM. Does the VCM or ACM feel any
Figure 4.2 Mode role-play of schema modes in action. Scene 2: This is what begins to change during Schema Therapy
more heard? (The VCM may say he/she is a little less scared as the PPM is less loud, but his/her needs are still not met.) So, we need to make some more changes. How can we help the GP reach the child modes? Oh, so you think that we need to do something with the MCM. [To the GP:] What do you think we need to do?

[T2 becomes more active as GP.] I think that the MCM could move away from the ACM a little bit so that I can get closer, but still stay on guard near the VCM. Would you do that? (The MCMs will argue some.)

The GP’s goal is to convince them to move over by reassuring them that she will listen to the ACM and they can be on reserve in case a survival situation occurs and they are needed again. The GP also tells them that they did a good job of ensuring the VCM’s survival as a child and that was very hard work, but that they don’t have to work so hard today as the HAM is there for that purpose and so are you. At this point, T1 as HAM can tell the PPMs to get a bit louder to test things and help the HAM in training shut them up again. This demonstrates that the PPMs may pop up again, but can be sent away as they truly do not have the same power they did in the past.

The GP now connects with the ACM and listens to him/her, validates his/her anger, and connects by giving him/her the end of a towel or piece of fleece and tugs on it a bit with him/her like a tug-of-war to help release some anger. Next, T2 asks the MCMs to move away from the VCM so that he/she can be reached. T2 moves closer to the VCM, gives him/her an edge of the cloth to concretely connect to him/her. This positive nurturing interaction goes on for a while and the GP in training is pulled into it and is coached to say a few validating things (the script constructed earlier can be referred to).

T1 leads further discussion of the experiences of each patient in the mode they played and what they observed. At the end, T1 gives a kind of summary of what has occurred and links it to the course of change in ST. Figure 4.3 presents Scene 3 and the healthier mode configuration.
Good Parent (from therapist)

Healthy Adult (from therapist)

Vulnerable Child Code

Angry Child Mode

Old survival coping mode

Punitive Parent Mode

Door back to pain of past is sound-proofed & locked

Soothed & Protected

Emergency use only

Channeled

Healthy adult Mode of patient

Blocks negative messages

Moderated

Demanding Parent Mode

Figure 4.3 Mode role-play of schema modes in action. Scene 3: The results of Schema Therapy
OK, let's pull our chairs together again as a group and discuss this experience. So we saw how the MCM originally developed to keep the PPM away from the VCM, and they accomplished that, but in the process they did not hear what the VCM actually needed. As time went on, the MCM just kept everyone away and the PPM was long gone physically (sometimes even deceased). The ACM expressed the VCM need also, but no one heard him/her either. The GP could not reach the ACM or VCM until the MCMs moved to the side a bit. The HAM convinced them to stand at attention but move over. Then the GP could reach both child modes and do what a good parent should have done in their childhood. That allowed both the ACM and VCM to become less distressed and they could connect, which was their need. So this demonstrates for you what we are trying to do in ST in a nutshell.

This role-play exercise is usually quite powerful for patients. It helps them understand the way the modes work at a different level than the cognitive. They often remark that now they “get” some of the modes that they had not understood previously. The discussion can be guided in a number of directions based upon the modes dominant in your group. If there is time left over, you can do a list on the whiteboard about deciding to reduce one's use of the MCM that captures what you all observed in the role-play and provides the cognitive intervention that supports the experience they just had.
Group Exercise 3: MCM 1 – the Safe-Place Image

This is an image also used in other therapy models in which imagery of a safe place is used for distress reduction. A difference in the ST version is that it is completely individualized with no assumptions that a beach or forest or other scene will necessarily feel safe for an individual. Some patients, particularly those with BPD, will tell you they have never felt safe anywhere. The image should be one that meets the VCM need for safety.

Therapist Tip

We help the group come up with a safe-place image by offering what our safe places are. JF talks about being at her grandmother’s house in her flower garden or up in her attic sitting on a cedar chest. This often elicits a patient with a grandmother image as this is common. We brainstorm with the group for those who say they cannot think of one. We list many of the things that we have heard from BPD patients over the years: school, a particular teacher’s classroom, a safe relative, a friend’s house, a tree house, up in a tree, climbing a mountain, a trip to camp, riding your bike, an imaginary place like Oz, with a fairy godmother, at church, and so forth. We can honestly tell patients and you that we have always found a safe-place image for every patient, possibly because we expect to and will stick with it until we do. Keep in mind the possibility that someone will have had a bad experience or even been abused in one of the safe-place images given as an example. If that happens, it is important to acknowledge that we “are all different” and sincerely say some version of the following statement: “Oh, that is awful, you certainly won’t want to use that one.”

We use a variation of Young’s basic instructions for the safe-place image (Young, Klosko, and Weishaar, 2003). With a warm, soothing voice we ask them to close their eyes or look down and to be aware of what it looks, feels, smells, and sounds like in great detail. When we first work with the safe-place image we do not specify the age or mode of the patient, just that it is a place where they felt safe.
Sample Therapist Script: Safe-Place Image Instructions

You can use your image to soothe your vulnerable child or reduce high distress or to replace the upsetting images of flashbacks. Let an image come to mind that represents a safe place to you. Don't push it; just be open to whatever safe image occurs. It can be like a movie scene, slide, photo, or it may be an actual memory. It can be something from your life, imagination, a book or movie. You can bring anything that is safe and comforting into your image. Make it your own. Don't worry if you have some difficulty at first getting a strong image. We will discuss it in group and help you develop an image that works for you.

1. What do you see?
2. Can you see yourself?
3. How old are you?
4. What else do you see?
5. What sounds do you hear?
6. Does it have a smell?
7. How do you feel in this place?
8. How does your body feel?
9. Is anyone else there? Remember, only safe people are allowed.

Self-talk for the safe-place image: “I am safe,” “I control this space, no harm comes to me here,” and “I feel calm.”

Add your own words ________________________________.

Name your safe place so that you can bring it to mind quickly and easily. For example, “Grandma’s house, the Tree house at home, Mrs. Smith’s classroom.” ___________________

We give them the instruction to practice the image at least once a day. We also suggest that they create a visual representation of their safe-place image, by drawing one, or finding a picture in a magazine, or symbolize it so that they can put it where they will see it regularly.
Experiential Mode Work Assignments 1 and 7 – MCM 1 and 2: Safe-Place Image Practice

It requires practice for your safe-place image (SPI) to get stronger and more useful as a healthy coping substitute for the MCM. Record your practice on the form below and the situation, mode, and result when you chose to use the SPI.

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Group Exercise 4: MCM 2 – the Mode Dialogue
Role-Play Expanded

This time we want to give patients both the opportunity to play their own MCM and then to be in the VCM role when another patient is playing that same MCM. To allow all patients to have multiple opportunities to play different modes, there is only one exercise for this session used in a number of variations. Since most patients have more than one MCM, it should be possible to divide the group up into at least two MCMs and more if needed. Then pairs of patients can take turns in the MCM or VCM roles with the other patients and the therapists taking all of the other roles in the manner described in detail for Experiential Mode Work Session 1. Before you start the mode role-play you can have the patients who will be playing the same MCM break into a small group to work on the script for that MCM. They can use the script from Session 1 as reference and add to it. The variant they will be working with may not have had a script made and in that case they have that task. The therapists can help as needed.

Only have one patient in the Dysfunctional Parent role and let them choose PPM or DePM. That will leave a patient over to take the Happy Child Mode. This time, have a patient volunteer take on the Healthy Adult Mode role and the Good Parent Mode role. One therapist should take the role of HAM’s helper and take on the task of directing and stopping the action. The other therapist can take the Good Parent helper role. That role assignment allows the therapists to be coaches to the patients in the healthy roles. These changes give patients the opportunity to experience a variety of different modes.

Sample Therapist Script

“Hello, I am glad that you are all here and I am happy to see you. As you know, this is the Experiential Mode Work Group and our focus today is on the Maladaptive Coping Modes. Today we will be working with the mode role-play again. So remember the HAM is the director of action and all the other modes must follow his/her instructions. The “Good Parent” role has the task of reaching the VCM with some of the messages we have identified as important over the last sessions. The MCM tries to protect the VCM by focusing completely on keeping the PPM or DePM away. If there is an ACM, he/she reacts intensely to the VCM’s unmet needs. So let’s get our various positions in place and get ready to start.”
At this point in treatment we would not expect a patient to refuse to play a role. If they do, as before ask them to be a helper to the HAM or GP. If they still decline, you can ask them to take the role of an observer and rate how effective the various modes are in their jobs.

"The first thing we will do is let the modes all play their roles and see what happens. That means that at the count of 3, I want each of you to be in role and say your script lines, adding other statements in role if you like. 1, 2, 3 – go."

Let the ensuing chaos go on for a few minutes. Remind the HAM patient to direct the volume of the modes in their role. Then stop the action and discuss what happened.

"OK, now everyone stop. Just take a breath. Let’s talk about what happened. We will start with the VCM – was your need taken care of? Were you protected? ACM – were you heard? MCM – did you hear what the VCM said – he/she was not protected? That was your job, how do you think you did? VCM – how did he/she do at protecting you and meeting your needs? MCM – did you even hear the VCM? Were you aware of his/her need?

How did it affect the role-play that the PPM was more out of the picture? Was the PPM less intense? Let’s make it that way for the next role-play we do.

GP – were you able to reach the VCM or ACM?

How was this the same or different from the last role-play we did?

OK, now that we have seen the way the modes were functioning now – let’s allow HAM to make some corrections. [To the patient playing HAM:] What do you want to change – for example, do you want to put the PPM out the door? Do you want to move the MCM out of the way? And so forth. [Make these corrections] Let’s go again and see what happens with these changes.

[Continue in this manner until all patients who want to have an opportunity to play the MCM and the VCM. Encourage patients to alternate playing the HAM. Coach the HAM and GP patients as needed.]"
The goal of these repeat role-plays is to give patients experiences of being in mode roles as parts of their mode system change. The therapists will need to direct the discussion by asking questions to bring out the aspect of change. For example, *what happens to the VCM when the MCM is farther away?* The answer may be that the GP can reach her, but it feels a bit scary as it is not what he/she is accustomed to.

“OK, let’s pull our chairs together again as a group and discuss this experience.

1. Were the VCM’s needs met?
2. Did the MCM step aside?
3. Was the PPM banished? Or was the DePM moderated?
4. Was the ACM heard?
5. Did the HAM make sure the VCM’s needs were met? Did HAM do a better or worse job compared to the MCM? How was it different?

The discussion can be guided in a number of directions depending upon your group’s needs and modes. If there is time left over, you can again do a list on the whiteboard about choosing to reduce one’s use of the MCM that captures what you all observed in the role-play. One would expect it to be different than the first time this exercise was conducted in *Experiential Mode Work Session 1: MCM 1* as patients will have increased awareness of their mode experiences and improved management of unhealthy modes.
The first exercise we use – the “Punishment Experiment” – is designed to contradict the belief of many patients that the PPM is “necessary” and even helpful for their performance. This exercise demonstrates the negative effects of DyPM messages on performance, contrary to what patients are taught and tend to believe. After the usual “Welcome to today’s Experiential Mode Work group message,” put the work you will be doing with the Dysfunctional Parent Modes into context with the following:

Sample Therapist Script: Punitive Parent Messages

Often when we talk about the PPM, patients tell us that “punishment is necessary” for children to learn or that “demands and pressure” make children achieve more. Does anyone here believe that? [Follow with these additional questions if necessary] Even a little bit? Or you believe it but think that we won’t want you to, so you aren’t raising your hand? [Short discussion of this content – 5 minutes] Well, today we are going to do a short experiment to investigate the effects of the Parent Modes on performance.

Sample Therapist Script: The Punishment Experiment – 20 min

OK, we need everyone to divide up into pairs. I have enough dowel rods here (a piece of wood rounded and 14–20 inches long, or some other object that can be balanced on a hand with some level of difficulty) for every pair to take one. Now the task is simple: you just need to balance the rod on the palm of your hand for about one minute. It needs to be the flattened palm or it would be too easy and you could just hold onto it. So one of you goes first, and the first time you attempt to balance, your partner will
We give patients the handout Experiential Mode Work Session 2 – DyPM1: Punishment and Reinforcement: How Do We Learn? (EMW 2-DyPM1) to keep as a reminder of this experience and evidence to use to contradict their DyPM messages.

Discussion:

- What does your Vulnerable Child feel about the exercise?
- What does your Healthy Adult conclude from this exercise?
- How could your Healthy Adult act to limit the damage to your VCM from the PPM?

We give patients the handout Experiential Mode Work Session 2 – DyPM1: Punishment and Reinforcement: How Do We Learn? (EMW 2-DyPM1) to keep as a reminder of this experience and evidence to use to contradict their DyPM messages.

Experiential Mode Work Session 2 – DyPM 1: Punishment and Reinforcement: How Do We Learn?

The Punitive Parent says: “When people make mistakes, they need to be harshly punished! That is the only way they will learn! Otherwise, they will keep making stupid mistakes and harm other people or annoy me . . . .”

Is this really true? Is harsh punishment really the only or best way to learn? Let's look at how punishment actually affects people. There are two main forms of punishment: either taking pleasurable or
even necessary things away to punish kids (e.g., you are not allowed to watch TV today or no dinner for you) or unpleasant things are done to them (e.g., you have to sit quietly for a long time, or you are beaten). Both things make kids learn not to do the “mistake” again … but … the punishment method has other unhealthy effects.

The exercise we did in group demonstrates the downside of punishment. When people get punished, they start feeling bad about themselves and often think they are incompetent. They get really scared of trying again and will avoid doing new things. Now take a close look at children … children need to explore the world, find out what they like and dislike, and form their own conclusions about how things work. This has to be done by trial and error and requires having a safe base in the form of an early caretaker. The child can explore from their safe base, and return to it if they need help or something seems scary to them. A good parent provides a safe base.

In contrast, the punitive parent might be disinterested (withdraw attention), which could make the child really insecure in exploring the environment or the punitive parent would punish it by saying things like “Don't touch that. You are such a bad kid for always walking away.”

A good parent on the contrary would reinforce the child for exploring. The good parent would, for example, make eye contact, pick the child up, when it wants to be picked up, or say things like “Wow, what are you looking at there?” to express interest in the child. The good parent might even go look at things with the child. And if the child made a mistake (for example, run too fast, hurt themselves and cry), instead of punishing it more, a good parent would soothe their child.

Punishment is not the same as healthy protection or limits and naturally occurring consequences. Parents need to inform kids, depending on their age, about the consequences of their actions in the outside world. For example, if you steal something at a store, the police will be called. If you skip school, the school gives a penalty and you may not learn things you need to, and so forth. If you yell at friends and hit them, eventually they won't want to be your friend. We all have some consequences for our actions.
Good parents provide guidance about what the consequences of actions are and guide their children to make good choices. Parents will dislike some actions and tell children not to do something again. If a person or animal is hurt deliberately or the property of someone else is damaged deliberately, progressive limits need to be set to stop the behavior. This is true in therapy also – there is support for trying things and realistic limits when needed.

Harsh or extreme punishment in childhood is the foundation for the Punitive Parent Mode. A harshly punished child learns to be punitive to themselves and to others, including possibly their own children.

If the “mistake” was a normal child need like hunger, asking for a hug, or asking for help, then the punished or ignored child may learn not to act to get their needs met or to ask for help. Those experiences can be the foundation for the Detached Protector or Angry Child Modes developing.

If the “mistake” was healthy child exploration or curiosity, punishing this can lead to an adult who has an undeveloped or unstable identity. That child can become an adult who won’t know what they like and dislike, what makes them happy, or even what is bad for them.
Group Exercise 2: DyPM 1 – Getting Rid of Dysfunctional Parent Mode Messages

After we have created some doubt in patients regarding the value of the PPM, we move to the next step – facilitating them having the experience that their internal DyPM is not him or herself, but something that was taken in from early experiences and can be gotten rid of with some work. One of the ways that we demonstrate this experientially is the construction of effigies to represent the DyPMs. Using a tangible representation serves a number of therapeutic purposes. It demonstrates the theory of ST that this is an internalized negative object, not the patient and usually not completely a parent. The first step in eliminating the DyPM is the patient understanding that it is not his/her voice. Patients typically draw a face on the effigy, which looks like a monster or demon. This characterization is useful as it does not even look human, underlining the point that the DyPM is the selective internalization of only the negative aspects of caregivers, not the whole person. This is helpful for two reasons: patients don’t think that they have to separate completely from their actual parents and from any good present in those relationships, so abandonment fears are not stirred up, and we do not run into family loyalty issues as much. The DyPM effigy evokes a lot of emotion, beginning at times with fear, but moving on to anger and rejection.

We first use the effigy as a site for patients to write the negative messages from the DyPM on. This process is another concrete action to get the messages out of the patient. We have them think about getting rid of the message by leaving it on the effigy. We later use the DyPM effigy in mode role-plays as a mask for the patient playing the DyPM, or it can be draped over a chair to add realism to a mode dialogue in an individual session. The figure can be stomped on and even torn apart. Throughout the experiential group sessions we keep the effigy available but out of sight in case patients come up with another message to leave on it. The therapists always take it away at the end of sessions. These actions demonstrate at a child’s developmental level that the DyPM is powerless now to do harm. The “Good Parent” figure therapists can easily control this effigy DyPM. In Experiential Mode Work Session 7 – DyPM2 we will describe using the effigy in mode dialogue role-plays.
In the ST Education sessions we told you about the normal needs of young children and the effects of not having those needs met. We also talked about how we internalize what the important people around us in childhood say about us and how they describe us and how these messages stick, whether they are accurate or not. To give you an example [substitute an example here from one of the therapists that is not too extreme] – I received the message from my mother that I was “difficult.” I am not sure whether she said it in those words, but that is what I remember as if that was a direct message from her. Based on that message – whenever I had problems with people close to me I said to myself “oh, this is happened because I am ‘difficult.’” At the cognitive level it developed into a core belief about myself and at the emotional level when I had that thought I felt queasy in the pit of my stomach. I came to understand as an adult and in my own personal therapy that this “difficult” label was not really about me, it was about my mother. I was “difficult” for her, because I spoke up. I was not like her – and that made me difficult for her. I discovered that many people appreciated that characteristic, but my mother did not, so I got that label. That message is part of my Demanding Parent Mode (DePM; and it is one I am alert for so that I can fight it if it comes up). So what we are going to do first today is talk a bit about what the negative messages are that you have from your DePM or Punitive Parent Mode (PPM) and then we will start our work to get rid of them and learn to fight them.

Facilitate about 10 minutes of discussion. Usually patients have little difficulty coming up with negative messages about themselves.
OK, so now we are going to get rid of these messages symbolically and literally by writing them on an effigy we will make to represent the whole group’s Dysfunctional Parent Modes.

First we need to draw a face for our effigy. [The cloth, muslin or other inexpensive fabric, has been cut into the shape of a large person, or can be a rectangular piece to have the body drawn on. We encourage patients to be involved in drawing some part of the effigy, but do not insist on this. We always try to let patients move at their own speed in the experiential work.] Wow, that is one monstrous Dysfunctional Parent we have made. I guess that makes sense, because it isn’t really one person or even a person, rather what is left with us from negative experiences with authority figures in the form of the parent modes. Now the fun part: we can leave any PPM or DePM messages we have on this effigy. [Patients are encouraged to write messages on the effigy using cloth markers the therapists provide. Sometimes patients are slow in getting started, so we often start. Fairly quickly most patients do get involved.]

Once the effigy is completed, one of the therapists can demonstrate its current powerlessness. Allow 30 minutes to construct the effigy.
Group Exercise 3: DyPM 1 – Things a “Good Parent” Would Say to a Loved Child

This is one of the foundation “group as a whole” imagery rescripting exercises we use.

"Sample Therapist Script: Good Parent Message"

OK, so now we are going to switch to something positive and healing for your VCM. We will replace those negative messages you just got rid of with the ones you needed to hear as a child. Please take out your Experiential Mode Work Exercise 3 – DyPM1: Fighting the Punitive and Demanding Parent Modes: Things a “Good Parent” Would Say to a Loved Child (EMW 2-DyPM) and take a few minutes now to write down the messages you would like to have heard from a loving parent as a child. Let’s hear what people chose. What is your favorite one? I’m going to write all of them down so that we can make a group “Good Parent Message Script.” [Allow 25 minutes.]

The assignment asks that the language be young child level (e.g., “I love you just the way you are,” “You are precious to me,” “I am so glad you are my kid,” “You are a really great kid,” “I will always be here for you,” “I will protect you.” If it is something older like “I am proud of your accomplishments,” translate it – for example: “You are just great” or “I’m happy that you are my kid.” They bring their list into the group and we discuss their messages. We get their permission for the group to borrow ideas and statements from each other, as invariably some will say that they could not come up with anything. While patients are sharing their choices, the therapist is writing them down to construct a collective “Good Parent” script.

1. Before we begin I am going to put the safety bubble around all of us. Let yourself feel the warmth and protection of the bubble for all of us. Remember that we will keep your VCM safe here. Now connect with your VCM. Do that in whatever way works for you – you can think of a picture of yourself as a young child or connect on a feeling level – however you are able to make that connection is fine.

2. I want to tell you some of the things that you should have been told by a loving parent and any other people taking care of you in childhood. I really want your Vulnerable Child Mode to hear these things as they are things that all little children need to hear and deserve to hear."
Then one of us reads the script in as warm, soft, and caring a voice as possible. We add in some of our own “Good Parent” messages. It is particularly important for the therapist who is not reading the script to add a number of statements to the script.

3. I want you to really hear me and be open to taking these statements in. If you get interference from any Punitive or Demanding Parent Modes try to kick them out, tell them they are not allowed here – only Good Parents can come into our group space. Try to remember the things you are hearing that you like best, because we are going to do something special with them. If you have trouble remembering, don’t worry; I have it written down and will help you remember.

[When the script is finished:]
4. Come back slowly to the group, remembering what you heard. We will discuss what this exercise was like for you.
5. Could you take it in from your VCM?
6. What did you hear that you liked best?
7. Were there any surprises for you?
8. Was there anything you had trouble with?

The group discusses the experience, how they felt, could they stay in their Vulnerable Child Mode, what did they like best, and so forth. You can give patients an audiotape and/or a written copy of the script to listen to, re-read and carry with them. The assignment after this session is to do something once a day to remember the experience of listening to the Good Parent Script.
Come up with a list of things that you think a good parent would say to a young child they loved and that you either heard or would have liked to have heard as a child. Try to use “kid language.” Your Vulnerable Child still needs to hear these expressions of love, comfort, protection, and validation. Example would be: “I love you,” “I am glad you are my kid,” “You are great,” and so on. We are going to use these statements in a creative way in a group session, so please give this some thought and write down some things. Feel free to borrow anything you have heard in groups, from therapists, and so forth that your VC liked. We will compare notes and add to the lists in the Experiential group session for the Vulnerable Child Mode.

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<th>I like hearing or would like to have heard the following as a child and my VCM still needs to hear: Write more on the back if you like.</th>
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Add to your list anything you hear in the EMW-2 group that your Vulnerable Child liked:
This session focuses on whole-group mode dialogues or role-plays in order to give each patient time to have one focused on their specific needs and content. We prefer mode role-plays to imagery rescripting for challenging and banishing the DyPM as a group mode role-play involves everyone actively and feels more powerful. Rescripting is easily done in the individual sessions. The DyPM banishing role-play can be adjusted to match a patient’s pace. A fearful patient in VCM with little connection to the HAM can observe and see that nothing bad happens. They can even observe someone else banish their DyPM. This kind of vicarious learning can be an important first step for avoidant and anxious patients. Depending upon their need, patients can position themselves behind the therapists for safety, be part of the group supporting the “banisher,” or they can stand directly with him/her. While observing, the patient should be in whatever degree of safety he/she needs – for example, safety bubble, covered up, holding co-therapist or other member’s hand, and so forth. The “banisher” may start out with the therapist speaking to the DyPM for him/her. Patients can begin to speak from the safety of the group when in the VCM and then in stages move to the front as their Healthy Adult gains strength. The tangible experience of the collective strength of the group effectively combating and eventually expelling the DyPM has powerful effects in diminishing the intensity of this mode. We have seen patients begin in fear, take in the group’s strength, and move in the same session to confronting their parent from the Healthy Adult. We use the effigy as a mask for the person playing the DyPM. We do not want any residual DyPM “energy” attached to the patient who plays that role. We want the Punitive Parent to remain something “not human” that was taken into the Vulnerable Child and needs to be eliminated. We do not have either therapist play the DyPM role. We are working to be seen as the “Good Parent,” so playing the DyPM has the potential to be too confusing at the level of the child modes. Be sure to check after DyPM work that group members feel safe before leaving the session. Create contingency safety plans if they have safety concerns. Finish the session with a longer return to the safe-place image or safety bubble that includes the instruction that the DyPMs are safely locked away.
Hello, I am glad that you are all here and I am happy to see you. As you know, this is the Experiential Mode Work Group. Today we will be using the mode role-play again, but this time we will be banishing the Punitive or Demanding Parent Modes (PPM or DePM). This role-play is set up a little differently. How many of you feel that you are at the point where it is time to banish your PPM (substitute DePM throughout the session if that is the mode you chose to work on)? Great. Well, to do that one at a time we are going to have a dialogue between you and your PPM. This is something that it is best to do from the strength of your Healthy Adult Mode (HAM). It is also something that you can have as much support as you need for. You can have the support of other group members, the therapists, a whole army.

We will need someone to play your PPM and another to be a support to that person. The person playing the PPM will have the effigy to use as a mask so there will be no confusion that it is not them personally, but just a role they agreed to play.

There is also more than one way to banish the PPM. If you do not feel ready to do it, we can play all of your mode roles and let you observe us doing the banishing. Does everyone understand what I mean by that?

Who would like to go first as the banisher? Who feels able to play the PPM behind the effigy? Who will support the person playing the PPM? You notice that I did not say support the PPM, rather the person playing that role.

Let’s set the rest of us up so that everyone feels safe enough and the banisher has enough support. [Have a few people move chairs near the banisher.]

If any of you are in touch with your VCM, this could seem scary. Why don’t any of you feeling that way come over and sit behind me and T2? We want everyone to have what they need to feel safe doing this.
This experience is processed with the whole group and then repeated with a different patient as the protagonist. Those who have not taken a turn should be offered a number of more supported options. One example is the therapist speaking to the PPM for them. As stated earlier, another is to have the group and therapists play all the roles. End the session with the therapists reading the Good Parent Script that the group developed previously. For an assignment repeat Experiential Mode Work Assignment 2: DyPM1.

OK – [to the banisher] Tell your PPM what you want to say to it. [This is done and the PPM answers back. We let the PPM answer back up to three times. If needed we jump in, asking the banisher if we can also speak. We want to tell the PPM how much they have hurt the VCM. We do not debate the PPM or let the “poison” of its messages out onto the VCM of the patients. We stop the action and turn to the banisher and say some version of: I think that we have heard enough. It is time to throw this old _______(expletive – bitch, bastard, etc.) out! [One of the therapists takes the effigy away from the PPM and gives it to the banisher.] You can throw it against the wall, out the door, stomp on it, whatever you like. It has no power now. Can you feel that?
Group Exercise 1: VCM 1 – Rescripting a Childhood Experience of the Therapist

Sample Therapist Script: Group Imagery Rescripting

We will begin by giving you an example of how imagery rescripting works by T1 sharing a situation where he/she needed a good parent in childhood and no one was there in that role. We will ask you to observe the situation.

Using self-disclosure in this way allows patients some distance at first in imagining the therapist’s childhood situation and facilitates their self-disclosure. It shows them how we do imagery rescripting and reduces their apprehension. It also demonstrates that we all have modes and it can make the therapist seem more real and genuine, thus fostering the connection with her.

1. Connect with your safe-place image (SPI). We will stay there 1–2 minutes. I want you to remember that your SPI is there for you and you can return to it any time you want to in the session today. OK, open your eyes and come back to the group.

2. I am going to tell you about a time in my childhood when I needed a good parent and no one was there to fill that role for my VCM. What I would like you to do is imagine yourself (here fill in details from your own scene) outside of a souvenir store looking in through a big picture window that allows you to see everything that happens inside. I was 6, in a little souvenir store picking out my souvenir from the family vacation. I really looked forward to that because I collected souvenirs and it was one of the ways I connected with my mother who was not very emotionally expressive in general but excited about her collection. I found a snow globe that was within my dollar budget, but when I picked it up it was slippery and I dropped it. It smashed and splattered everywhere. The store owner yelled at me and made me pay for it with the one dollar I had. My mother was there and did nothing to help or defend me. I was devastated, but didn’t cry because we were with my uncle and my cousins and I was embarrassed. I felt like a bad kid, that I had made a terrible mistake. It also gave me the message that I would be all alone if I got into any trouble.
Group discussion has patients sharing what they observed. The other therapist asks them questions like:

3. What do you think T1’s little child felt and what did he/she need?
4. What would a good parent have done differently?

Encourage them to ask any questions they have about the experience. T1 also tells them what the link to a problem of moderate level in current life is.

5. As I tell the memory it doesn’t seem so big, but I know that it is related to my unrelenting standards schema and part of why I still have a big reaction today when I make even a small mistake. I have worked on it and I catch that reaction (which is a good example of my PPM), but it still pops up sometimes.

6. [The second therapist leads this part of the imagery work. T2 begins by asking the group:] How can we work together as a group to change the ending now? Let’s brainstorm.

7. [T2 says:] Now, (name of T1), can you go back into the image and connect with little X and this time the rest of us will join you? I am going to play not T1’s mother, but a good parent, and I want the rest of you to be there watching and see how our script affects little T1. Watch what happens to the little child’s face when a good parent defends and comforts her. [T1] OK, let’s go back to just after the snow globe smashes and I’m there as the Good Parent (T2 plays this role dramatically). Oh, T1, honey are you alright? Let me get you away from this broken glass. Poor baby, are you hurt anywhere? Don’t worry, you are not in trouble – it was an accident. [To the shopkeeper firmly:] Stop – do not yell at my little girl! Can’t you see that she is upset, she is a child and you have no right to yell at her? Talk to me about this. I am her mother and I will be responsible for any damages. [To T1] It’s OK dear, you didn’t do anything wrong, it was an accident. I know that you really wanted a snow globe, I think they are pretty too. [To the shopkeeper:] Here is $2.00. One dollar for the broken one and one for the new one you are going to bring out for my little girl. The shopkeeper pulls a new one out from under the display – and it slips out of her hands and breaks.
The group and therapists come out of the image and discuss what they observed. This is an opportunity to underline how a good parent would act and the very different effects when T2 played the mother. T1 shares what the rescripting was like for him/her. The joke we threw in to the example is not required. We add it to show that we can still have some playfulness to balance doing difficult work; many patients report liking that part best.

[T2 in the role of a Good Parent says:] *See, all of us can have accidents. [To the shopkeeper:] I hope that you have another one, but if not there are a lot of other stores here we can shop in.*
In shifting to rescripting patient memories, we start with a short image that introduces the therapist entering the image with the patient observing the interaction with the VCM.

**Sample Therapist Script**

1. “OK, I want you to go back to a time in childhood where you are in a situation as your Vulnerable Child Mode where you needed a “good parent” and no one was there. Just focus on whatever comes to mind as a time when you really needed a good parent to be there for you.”

Judging by their nonverbal behavior, we let the group go for two minutes or stop sooner if there is too much overt distress. In this early work we want patients to realize that they can visit uncomfortable memories for a short time and not be completely overwhelmed.

2. Now open your eyes and come back to the group and let’s talk about what situations you remembered.

We try to get everyone to share something from their experience. If someone does not come up with one, suggest they may think of one as we talk more and they should feel free to add a memory later. Next, we go back to the uncomfortable image. If someone has brought up abuse or trauma, have them go back to the point before anything really bad happened.

“OK, go back to that image just for a minute or two and really be aware of what you needed as that little child.”

Have them again come back to the group. This is good practice in asking for needs directly. Also, it ensures that we will know what needs to be met in their imagery when we go into it as the Good Parent figures.
So now briefly tell us about your image – who was there, how old were you, and so on. What were your needs? We encourage them at this point to continue using “I” language.

Go back now to that same image as your little child. Be your little child.

Sample Therapist Script: Being a Good Parent for All of the Group Members’ VCM

Listen to my words and take all of them in for your little child. Imagine me coming into your image to be the good parent you deserved, to comfort and protect your little child. Just listen to what I say to your little child – I am here so you don't have to be scared. I’ll protect you. No little child should be left alone like this. You are precious and deserve protection.

Now imagine me coming into the image to meet whatever your little child needs. Whatever your child’s needs are, I am meeting them. Try to just take in the experience of having your needs met as your little child. Know that I will ask nothing in return, there is no price tag. You are a young child who needs some care, deserves to have his/her needs met, and I am giving that to you. I know that your mommy and daddy did not always understand you and realize that you needed affection, love, protection, and so forth. What you need to know is that you deserved those things – all children do and you did too. Just because the adults around you could not give that to you does not mean that you did not need and deserve it. The little child part of you is the part that feels emotional pain. The little child needs to feel some of the nurturance and comfort that she did not get in order to heal and not feel so wounded. When this happens you will not feel as much pain. Imagery work is the way to reach early memory and repair faulty feelings of being wrong and bad that come from early experiences. You were not bad or wrong, those experiences were bad and wrong and it was wrong that you were not protected. We all know that children should be protected.

[Pass around squares of soft fleece.]

The fleece we are giving you now is for your little child. It represents the softness and comfort that we want to give her and that she deserves. Use the fleece to remember our healing work with your little child. Let it represent the needs that she deserves to have met.
Here we have made the transition to him/her being the child, not just seeing him/her.

Now when you open your eyes, try to let your little child be present and take in the circle of little friends that you have here. These are friends who will not purposely hurt you and who know the pain that you carry and struggle with. [Give them a few minutes.]

Let’s talk about what you experienced.

After each image, we process the experience as a group. This processing is an integration of the cognitive and experiential aspects of the imagery change work. The therapist pulls out themes to support the overall idea that the child was mistreated, did not deserve that treatment, was not bad, the parent was wrong to treat a child so harshly, and so on. Ask about any mode interference they experienced – for example, PPM messages, Detached Protector.
Group Exercise 1: VCM 2 – Little Child Alone on the Street

The next imagery exercise is one that we use both to assess the relationship between the patient and the Vulnerable Child Mode (VCM) and to develop some compassion for him/her. It is also the first step in the transition to the patient starting to find his/her inner Good Parent, which we see as the part of the Healthy Adult Mode (HAM) that will eventually care for his/her VCM.

Sample Therapist Script: Little Child Alone on the Street

We would like you to close your eyes or look down and try to imagine the situation that we will describe to you. Just be aware of any thought, feeling, or mode that is present.

1. You are walking down the street toward your home and you see a small child ahead of you. Your first reaction is that she is too young to be out alone, only 3 or 4 years old. As you get closer to the little child you notice she is crying and hanging her head down. When she sees you, she keeps her head down, but raises a hand up to you in an imploring way.

2. You take her little hand and start telling her reassuring things – like you will find her mom, she is safe, and so forth.

3. You decide to take her home with you so you can call the police to help locate her family. She very willingly goes along with you, holding your hand. She stops crying and smiles at you.

4. How do you feel? What do you do? How do you continue to try to take care of her? (If there are both genders in your group, change to he/she.)

In the ensuing discussion point out the various Good Parent skills that patients used with this little stranger. Next, have them once again close their eyes and listen to the image you describe.
5. So once again you are leaving your home and you see a little child sitting in the street crying. You walk up to her, telling her comforting things (you can use some from the discussion if you like). This time, as you get closer she raises both arms toward you to be picked up. You decide to pick her up and as you do you realize that she is you as a little child.

6. How do you feel? What do you do? How do you continue to try to take care of her?

After a minute or two, have everyone open their eyes and come back to the group.

This exercise can be quite emotionally evocative. It is a first step in asking patients to care for their VCM. This exercise gives you information about how much or little compassion the patient has for their VCM. A number of our patients reported that as soon as they realized they were the child, they wanted nothing to do with him/her. A few patients even reported dropping the child. Some were able to continue taking the child home, but then said: “Since it is me, I do not know what to do with her.” This is not due to a skills deficit, rather a discrimination error in not matching caretaking skills they use with others to meeting their own VCM need. Their responses provide openings to introduce the idea of compassion for the little child they were, who did not get needs met and needed love and comfort as much as the little stranger child on the street. Barriers to self-compassion can be identified – like faulty beliefs that their child is “bad,” “undeserving of love,” and so forth. You can go over some of the information from ST Education groups about all children deserving to have needs met and issues like how does a young innocent child become “bad” in their eyes. It can be useful to do the exercise again with the patients knowing it will be their child, with instructions to try to comfort and take care of the child like they would a real child of their own or a beloved niece or nephew or grandchild.
Group Exercise 2: VCM 2 – Imagery Rescripting
Patients’ Memories

Sample Therapist Script: Introducing Patients’ Rescripting

Do all of you remember the VC session six weeks ago where we rescripted a time from my childhood where I needed a good parent and no one was there for my VCM? [Say some detail to remind them if needed.] Did that example from my life remind anyone of a similar incident in which you needed a good parent and no one was there? [Some discussion of examples] Would one of you like us to work on your situation the same way we did for me? [Usually someone volunteers. If not, you can do some gentle nudging by asking one of the patients who gave an example if they would work on that one.]

OK, we will go through the same steps as we did for the therapist example.

1. Describe the situation. [When they get to the “no one was there” part, be ready to stop them before details of abuse are shared and explain in a very gentle way that “we don’t want you to re-experience trauma –we want to stop before something bad happens to your VCM child and change the ending to what should have happened with a good parent there doing their job.”]

2. What does (patient name) VCM need? How could a good parent meet those needs in imagery? Let’s form a plan.

3. OK, now go back to the point of the need and I will use the plan as a good parent would. We would like everyone to let your VCM take in the soothing and comforting things I will say.

4. Have all come out of image and discuss their experiences, starting with the patient who volunteered their situation.
I want to acknowledge all the hard work we have done today. I also want to end the group with a short Good Parent image for all of you. Just close your eyes and imagine T2 and I there with your VCM holding his/her hand in support. Now imagine all of the Good Parents of the group members, including yours, circling around us for support. Let your VCM take in all of the care and warmth and take his/her little hand in yours and give him/her a caring message from you. If that feels difficult, you can always say “I am learning that you deserved to be loved and cared for and to have your needs met.”
Group Exercise 1: ACM 1 – Tug-of-War

(Item needed: large towel)

I need two volunteers. [Give each one the end of a large towel.] Now, when I count to three, I want you to pull hard enough to lift the other off his/her chair. There is one rule – as soon as someone starts to be lifted up out of their chair, STOP. Now, the rest of you have a role also. This half will cheer for patient A, and this half for Patient B. I want you to cheer loudly for your participant, saying things like: “Go Brenda Go” and “Go Linda Go” or “Pull, Pull.” I also need two of you to act as spotters in case the “tuggers” get carried away and are coming out of their chairs – you will need to remind them to stay sitting, watching they do not fall. [After everyone is in place:] OK, are you ready to begin? 1, 2, 3 – GO.

After this exercise, ask the “tuggers” how they felt doing this exercise and what it was like to hear the cheering. Ask the cheerleaders what they felt cheering. Time permitting, let each member try the exercise. Another option is to have group members pair up to try the exercise. Again, ask for feedback from those that tried the exercise. You can point out how the muscles used to release anger in the tug-of-war game are the same ones we use when we hold anger in or are used in physical aggression. Often, when a person shoves down their anger, certain muscle groups are affected, like the shoulders, arms, back or jaw muscles. These exercises can help in releasing the body tension from these areas. Typically, at the end of the exercise the volunteer feels more grounded and, if he/she began the exercise angry, less angry.
Group Exercise 2: ACM 1 – Ball Making and Paper Toss

(Items needed: two old phone books, hand wipes, waste basket)

[Divide group into two teams and give each team an old phone book.]

Part One: Work as a team and try to outdo the other team by making the most balls using four to five phone book pages for each. You will have three minutes. On the count of 3, Go! [Declare the winner.]

Part Two: Stay in the same team. Each team should have at least 12 balls divided equally. One member from each team will alternate turns tossing balls into the basket. Team with the most successful balls wins. *Toss the ball with your non-dominant hand*

Group Exercise 3: ACM 1 – Balloon Work

This is an exercise to help release anger or to use during times of general “stuck-ness.” Give everyone a balloon and instruct the group members to imagine that they are to fill the balloon with either angry feelings or thoughts (or with things that might be keeping them stuck), but do not tie the balloon off. On the count of 3, everyone raises their arm and releases the balloon into the air. The balloons fly around the room, causing laughter from the participants. Releasing even a little of the anger makes room or space for more pleasant feelings to enter in.
Group Exercise 4A: ACM 1 – Balloon Pop

Everyone is given a balloon to fill and tie off.

“Place the balloon in front of your chair. Remain seated; try to break the balloon with your feet. Plug your ears if the sound is upsetting.”

Group Exercise 4B: ACM 1 – Balloon Pop

“After filling and tying off your balloon, place it on the floor in front of you. Break the balloon from a standing position.”

Group Exercise 5: ACM 1 – Construct an Angry Child Mode Image

(Items needed: old magazines, scissors, glue, and poster board)

Have group members look through magazines with the focus on finding pictures and words that fit for the Angry Child Mode. Each patient can make a mode collage that represents their ACM using the pictures and words. Give patients about 30 minutes for this activity.

“Come back to the group and present your collage and tell us a little about your experience making it – thoughts, feelings, if you were aware of the ACM – what effect did the activity have on him/her?”
Experiential Mode Work Assignments 4 and 10 – ACM 1 and 2: Anger-Release Practice

1. Try one of the Having Fun with Anger exercises from your session: for example – bat your PPM balloon around the room and finally burst it or sit on it.
2. Blow up a balloon with the idea that you are blowing into it all of your anger and frustration of the moment that is causing discomfort. Put the balloon in the closet or under the bed – somewhere out of the way – knowing that it will be there if you need to go back to it.
3. Do the paper wad – ball toss until you are tired.
4. Or try one of the other exercises from the sessions.

Write about what you tried and the result:
Group Exercise 1: ACM 2 – The Push-Back Walk

Have group members match up into pairs trying to keep the height about the same.

*One pair will start the exercise. For the rest of you, half will cheer for “X” and the other half will cheer for “Y.” On the count of 3, begin pushing back to back; no using your butt, try to push the other person until they walk from their stationary position.* [*Spotters needed.*]

Group Exercise 2: ACM 2 – The Punitive Parent Face

Everyone is given a balloon to fill and tie off, then, using markers, they are instructed to draw their Punitive or Demanding Parent Mode’s face. After everyone finishes they are told they can bat the balloons back and forth to each other, trying to keep them at first in the air by everyone trying to keep up balloons that come near them. Do this for about 12 minutes, then give the instruction that people can do whatever they want to the Parent balloon. Give about 5 minutes for this, then come back to the group circle and discuss what they chose to do with the balloon, what that meant to them and how they felt doing it. Inquire about any Parent Mode activity during the exercise.

Group Exercise 3: ACM 2 – Smashing “Eggs”

This is an exercise using imagery. Have the group imagine that they have been given a dozen eggs. On the count of 3, they are to imagine throwing the eggs against the wall, watch the yolk run down the wall, see the mess it is making. Discussion: what are some of their thoughts and feelings?
(Alternate exercise) Experiential Mode Work Session
10 ACM 2, Group Exercise 4: Group Stomp

Blow up and tie off 30 balloons and have everyone stomping at the same time.

*Group Exercise 5: ACM 2 – Mode Role-Play*

Another alternative activity, depending upon the needs of your group, is to set up the mode role-play of MCM 1 and let the ACM be the focus. You could have the ACM interact with the PPM, with the MCM. You could have one patient play the HAM and the Good Parent and interact with the ACM. A wide variety of options can be implemented based upon the ACM of your patients.
Group Exercise 1: HCM 1 – Creative Fun Exercises

Team activity: Play is our earliest experience of negotiating, meeting, forming friendships with others. When play is prohibited, people miss out on this foundation developmental experience. These group activities provide that experience and the various mode flips, feelings, reactions of patients can be discussed afterward.

Group mascot

(Items needed: general craft supplies, old hats, pieces of clothing, scarves, fabric, etc.)

Using any craft supplies, work together to create a group mascot. Your setting will determine what is available here. In some settings, play-doh or clay may be the limit of what is available to use as the medium. Other settings may have a wider range of possibilities. If an art therapist is part of your team, we suggest that he/she be invited to attend this session. Art therapists may be willing to assist the psychotherapists in leading the session and/or allowing it to be held in their work space.

Fun with the modes

(Items needed: old magazines, scissors, glue, and poster board)

Have group members look through magazines with the focus on finding pictures and words that fit a good parent. Each patient can make a mode collage using the pictures and words that represent a “Good Parent,” who would support the Happy Child Mode. Give patients about 30 minutes for this activity.

“Come back to the group and present your collage and tell us a little about your experience making it – thoughts, feelings, if you were aware of the ACM – what effect did the activity have on him/her?”
Group Exercise 2: HCM 1 – Fun for the Happy Child Mode in Imagery Exercises

“Everyone take a deep breath and listen closely to my story. Allow yourself to become a part of the activity as if you were a child of 6 years old. Pay close attention to my instructions and your feelings while participating. [Begin the exercise:] Oh, it is so good to see all of you today. I have a very big surprise for all of you. We are going on an adventure to a huge toy store, the biggest in the world. Wow! I can see how excited this has made you. I am excited too. Once we get to the store you will each have three minutes to pick out two toys that you have always wanted. You do not have to worry about paying for it because I won the lottery and I want to treat all of you. OK, the time starts now, and the first room we enter is the stuffed animal room. Oh my! Look at the size of that panda bear, it almost looks real. Teddy bears in every size and they feel so soft, giraffes, puppies and kittens, there are so many different kinds and sizes of soft animals here. Only two more minutes left to pick your toys. I see some of you running off to the Game Room and I can hear lots of laughter and giggles. Oh look! There’s a doll room with large and small dolls – Barbies, porcelain dolls in antique costumes, Madame Alexander, some of every type. There is a transformer room, battery operated cars, planes and trucks, science kits, magic tricks, and so many books. Someone just dashed off to the Disney room. One minute to go. Hurry, hurry! WOW! It looks like everyone was successful in selecting two toys. Let’s go back to our group room and talk about what you picked and why and what feelings were you aware of. Any mode flips take place?”
Group Exercise 1: HCM 2 – Creative Fun Exercises

(Items needed: craft supplies, shoe boxes, decorative paper, crayons, markers, ribbon, scissors, glue, buttons, stickers)

The treasure box

Use a shoe box and have the group members decorate the box with items from the list. Explain how the box can be used to hold mementos from the group or small items they hold dear –keepsakes, memories, and connection boxes.

Our groups regularly make these boxes, which they use for the treasures of their “little child.” Their collections consisted of small smooth stones or shell pieces from their therapists’ trip to the beach, crayons, bubble gum, pictures, bags of scent, cards, and so forth. Therapists and patients write positive affirmations on cards. Patients make things for each other, tapes of relaxing music, book marks, and so on, all of which serve as transitional objects. The box is a resource they can take out for soothing; they can look at the “treasures,” eat the candy, blow bubbles, and so forth. The box can be used to evoke the Happy Child or comfort the Vulnerable Child. Patients report that having this resource aids them in learning about comforting their “little child.” From their Healthy Adult Mode they can comfort the “little child part” by reading a card from the box, telling him/her about the objects in the box and why they are special as you would do to a little child, play the tapes, and so forth. We emphasize to patients that it is not possible to re-do your childhood, but it is possible to respond as an adult to the unmet needs of the Vulnerable Child Mode.

Therapist Tip

Some patients struggle with the treasure box exercise because it activates their Punitive Parent Mode. We acknowledge this and, as the Good Parents, offer to keep the box safe for them until they have diminished the power of the interfering mode. You can also use imagery like that below to deal with the PPM.
Group Exercise 2: HCM 2 – Imagery Exercise to Banish the Dysfunctional Parent Mode

This is little (fill in the name)’s time to play and have fun, to be free and explore, to claim being a happy little child. All children deserve this time. You did not allow it when they were children, but you are not in charge now. In fact, I want you to get out of here. Didn’t you see the sign on the door that said “NO NASTY PARENT MODES ALLOWED. ENFORCED BY THE MODE POLICE.” So out the door with you and don’t come back – there is no place for you here.

OK kids, the place is yours again. Run, skip, play, explore the play room all you want. This is 90 minutes just for you. Set up a game if you want and everyone can join in, we therapists too. All of us have a Happy Child Mode that needs to have fun and learn about what he/she likes and dislikes.

Group Exercise 3: HCM 2 – Happy Child Mode
Dream House Imagery

Everyone take a deep breath, close your eyes and connect to your Happy Child. Play close attention to my words and taking them in. [Begin:] There’s a knock on the door and when we open it we see a large box sitting there addressed to: “All the Happy Children in this room.” Let’s open it together and see what it is. Oh wow! It is a beautiful miniature doll house. But wait! There’s a note. [*Have your group turn this house into a dream house where they can each take a room to fill and decorate any way they want to. There is a separate room for each of you.*] Let us go to the
Experiential Mode Work Assignment 11 – HCM 2: Letting Your Happy Child Play

1. This assignment is straightforward and uncomplicated: do something purely for fun. If you like – repeat something from the Happy Child Mode group sessions. It must last at least 20 minutes.

   This assignment you do not have to write about – just allow your Happy Child within to play.

   Ten minutes total. Call everyone back to present their room and discuss the experience.

   miniature store and select the items you want for your rooms. Choose a paint color, or you might want wallpaper. Pick a soft rug. Don’t forget big fluffy floor pillows and a game chest. You might want an artist easel or a table for scrap-booking or playing with clay. Now it’s time to get the games and toys to fill your room. What did you pick? I can’t wait to see your room when it is completed.

1. If another mode interferes (e.g., the Punitive Parent), push it away and try to stay focused on the fun that your little child deserved and you even as an adult also deserve.

2. What Good Parent message can you give your DyPM?
Group Exercise 1: HAM 1 – Feeling the Effect of PPM and DePM Messages on the VCM

[For this exercise therapists need to have prepared a minimalist face of the VCM on a whiteboard or flip chart.]

1. In the Experiential Mode Work PPM session you wrote PPM messages on an effigy. What we want you to do now is write the message that troubles you the most on a Post-It note. [Therapists should do this too.]

2. To demonstrate the effect on the VCM of our having these messages, each of us will go up and put the message on the VCM. [Therapists should go first and place the messages right on the face as we want it to end up being covered.]

3. What was that like? [Expect painful, sad, or an MCM.] Did anyone notice a mode flip when you did it?

4. Well, our HAM is not going to tolerate those messages burdening the VCM for long. Each of us will go up and take our PPM’s message away and get rid of it. [Therapists go up, pull it off, and dramatically wrinkle it up and toss it away. As patients do the same, the rest can cheer, led by the therapists.]

5. What was that like for you? Did anyone experience a mode flip when you threw the message away? What mode do you think you were in taking that action?

6. So now the VCM can at least be seen.

What our VCM deserved to hear:

7. In this part of the exercise we are going to write as many Good Parent messages as we can think of on Post-Its. Think back to the messages you heard in the VCM session from the therapists and messages from the Good Parent Script. These are the messages that our VCM deserved to hear as a little child. [For this exercise therapists need to have prepared a PPM face on another whiteboard or flip chart. This can be a circle with minimal features, but a line or unpleasant mouth.]
8. OK, now we are going to each go up and smother the PPM with these messages. Here is the way our HAM can do it. [Therapist goes up first to demonstrate.] You should have said I was a wonderful child, you should have said that you loved me, and so forth. [Therapist should do about six messages quickly. As he/she does so, the other therapist should start the patients’ cheering at each positive message.]

9. One at a time, patients go up to the face on the PPM whiteboard and smack the post it’s on, saying with each one some version of “you should have said, you should have told me …” [Other group members support and cheer.]

10. We have managed to totally smother and wipe out the PPM. What was it like to do that? What mode were you in? Could you connect with your HAM?

Messages from the HAM to the VCM:

11. OK, the last thing we are going to do is write our most important HAM message to the VCM on a Post-It and go up and put it around the VCM. That will provide protection from the PPM.

12. [Patients write one more GP message – the one that impacted them the most today. Each goes up to put it on around the VCM face.]
Group Exercise 2: HAM 1 – Short Physical Grounding Exercise

Are you aware of your HAM now? [If not, do a short imagery to connect.] We are going to do a quick exercise to feel our HAM more. Stand up and really feel your feet and legs under you. Bend your knees just a little and feel your connection to the earth beneath you. Stand up really tall and feel your adult height. Take a few deep slow breaths. You are all strong, competent people who have survived a lot and deserve to heal the past. Feel your own strength and the support of the group around you.

Experiential Mode Work Assignments 6 and 12 – HCM 1 and 2: Developing Your Healthy Adult Mode

One major way to develop your Healthy Adult Mode is to strengthen the things that support positive thinking, coping and a plan for the future. Many different kinds of things fit in this category: a supportive relationship, a picture of a supportive person, a picture or symbol that represents an important characteristic you have, a note of encouragement, and so forth.

Assignment

Identify, and then try, at least two of the following kinds of “Healthy Adult strengthening strategies.” Write about what you chose and your experience with doing it.

1. Read aloud to yourself the encouraging words from others that you have written down. If you don’t have any, ask people for them. You can use the words from the beads.
2. Practice a healthy coping skill
3. Hold a tangible object, smell a scent, or look at a picture that evokes a feeling or positive connection.
4. Revisit positive memories from your group experiences (e.g., imagery rescripting, feelings of connection in the web exercise, sense of belonging and acceptance). Imagine that your mind is like a slide projector – put in a positive slide of a memory and if a negative slide shows up, eject it and put the positive one back in. Remember that we don’t have conscious control of every thought that comes into our heads, but we can do something about whether we let it stay or replace it with something else.

5. Visualize a dream you have for a healthy adult future.

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Group Exercise 1: HAM 2 – The Mode Role-Play

This time we want to give patients the opportunity to play the HAM and experience trying to manage the other modes. This is done with one of the therapists playing a helper to the HAM. The role-play can also be stopped at strategic points when a dysfunctional or maladaptive mode is operating and the patient playing HAM does not know what to do. One of the options for the HAM that should be underlined is that he/she can ask for help. HAM can remind other modes to use various skills and antidotes that he/she has learned so far in the treatment program.

Solicit volunteers for the other roles: one Good Parent (GP), one Vulnerable Child Mode, one Angry Child Mode, one Happy Child Mode, one Dysfunctional Parent Mode (let them choose PPM or DePM), one or two MCMs. Have a patient volunteer take on the Good Parent Mode role. One therapist should take the role of HAM’s helper and take on the task of directing and stopping the action. The other therapist can take the Good Parent helper role. That role assignment allows the therapists to be coaches to the patients in the healthy roles. These changes give patients the opportunity to experience a variety of different modes.

Sample Therapist Script

So remember the HAM is the director of action and all the other modes must follow his/her instructions. The “Good Parent” role has the task of reaching the VCM with some of the messages we have identified as important over the last sessions. The MCM tries to protect the VCM by focusing completely on keeping the PPM or DePM away. If there is an ACM, he/she reacts intensely to the VCM’s unmet needs. So let’s get our various positions in place and get ready to start.

At this point in treatment we would not expect patients to refuse to play a role. If they do, as before, ask them to be a helper to the HAM or GP. If they still decline, you can ask them to take the role of an observer and rate how effective the various modes are in their jobs.
Let the ensuing chaos go on for a few minutes. Remind the HAM patient to direct the volume of the modes in their role. Then stop the action and discuss what happened.

OK, now everyone stop. Just take a breath. Let’s talk about what happened.

We will start with the VCM – was your need taken care of? Were you protected? ACM – were you heard? MCM – did you hear what the VCM said – he/she was not protected? That was your job, how do you think you did? VCM – how did he/she do at protecting you and meeting your needs? MCM – did you even hear the VCM? Were you aware of his/her need?

HAM – how did you attempt to change the usual way these modes operate? How successful was your effort? What did you learn to use in the future?

How did it affect the role-play that the PPM was more out of the picture? Was the PPM less intense? Let’s make it that way for the next role-play we do.

GP – were you able to reach the VCM or ACM?

How was this the same or different from the last role-play we did?

OK, now that we have seen the way the modes were functioning – let’s allow HAM to make some corrections. [To the patient playing HAM:] What do you want to change – for example, do you want to put the PPM out the door? Do you want to move the MCM out of the way? And so forth. [Make these corrections.]

Let’s go again and see what happens with these changes. [Continue in this manner until all patients who want to do so have an opportunity to play the MCM and the VCM. Encourage patients to alternate playing the HAM. Coach the HAM and GP patients as needed.]
The goal of these repeat role-plays is to give patients experiences of being in mode roles as parts of their mode system change. The therapists will need to direct the discussion by asking questions to bring out the aspect of change. For example: *What happens to the VCM when the MCM is farther away?* The answer may be that the GP can reach her, but it feels a bit scary as it is not what he/she is accustomed to.

"OK, let’s pull our chairs together again as a group and discuss this experience.

1. Were the VCM’s needs met?
2. Did the MCM step aside?
3. Was the PPM banished? or Was the DePM moderated?
4. Was the ACM heard?
5. Did the HAM make sure the VCM’s needs were met? Did HAM do a better or worse job compared to the MCM? How was it different?"
Group Exercise 2: HAM 2 – Bead Exchange

In the last experiential group it is important to do something to symbolize the work that you have done that has contributed to strengthening the HAM. That is the overall goal of ST. We like to do a bead exchange. We supply a large bowl of glass beads that are very different in color, shape, size, and so forth. The patients some time earlier will have selected one for each member of the group to represent a HAM strength that they have observed in them over the course of the treatment program. They will also have prepared a small note card and written on it what the bead represents.

One person at a time will be given our beads and cards. These beads will be strung on a cord with the rest of beads the patients have accumulated from other experiential sessions. They should have approximately 14 beads, enough for a bracelet or key chain or “worry beads” to use for stress reduction. The beads are a transitional object representing what the members and therapists have seen in them and acknowledged through the course of the program.

Therapist Tip

Some patients have difficulty making eye contact or proclaim that they are too embarrassed to receive the beads. Here we push them to try to just take it in. It is OK to be embarrassed as you are not used to all these positives, but it is an important experience for you to have.

Sample Therapist Script

“In the future you can wear this or keep it with you in a purse or pocket or in your VCM treasure box or safely stored somewhere. When you take it out and hold it you can remember the experiences you have had here that have strengthened your positive sense of yourself and your HAM.”