ASSUMPTIONS ABOUT 'HUMAN NEEDS' AND ENABLED 'SUBJECT POSITIONS' IN SCHEMA THERAPY, INTERPERSONAL PSYCHOTHERAPY, AND GESTALT THERAPY

Seda Usubütün,
Department of Psychology, Ufuk University, Ankara, Turkey
Oguz Omay,
Department of Psychology, Üsküdar University, Istanbul, Turkey

Conflict of Interest

- NONE

Outline

- Positioning Theory
- Positioning in Schema Therapy
- Positioning in Interpersonal Psychotherapy
- Positioning in Gestalt Therapy
- Comparison of Therapy Approaches

What is Positioning Theory

- Moghaddam and Harré (2010) stated that positioning theory is about "**how people use words (and discourse of all types) to locate themselves and others**".

- People undertake **positioning acts**,
- and as such **they are** or **claim to be positioned** in certain ways,
- which endows them with the **right and/or the duty to assign or ascribe positions**.

Positioning Acts

- In a certain sense in each social milieu there is a kind of **Platonic realm of positions**, realized in current practices in a highly mobile and dynamic way. People can:
  - *adopt,*
  - *strive to*
  - *locate themselves in,*
  - *be pushed into,*
  - *be displaced from or be refused access,*
  - *recess themselves from and so on*

Rights, Duties, Obligations, Expectations

- Positions are inherent in the **storylines** that individuals construct and enact individually and interactionally.

- Positions involve rights, duties, obligations.
- **Expectations about** how an individual will enact such rights, duties, and obligations.
- Individuals can **take up** these expectations or position themselves to **oppose** those expectations.

Dynamic Alternative of Roles

- **Positions are dynamic**; participants in social contexts can both position and be positioned by others.
- **Positions can shift within social settings and through time**, as when an individual looks back on or reconstructs previous experiences and discourse.
- The concept of positioning can be seen as **a dynamic alternative to the more static, formal and ritualistic concept of role**

Possible Questions

- What are our own subject positions in therapy settings?
- What subject positions do clients take up in those settings?
- What identities are constructed through therapeutic exchange?
- What are the positions taken up by, resisted by, or forced on clients?
- How do storylines open up explorations of positions held by one's self and by others?
- How do our own positions and storylines echo the voices of others?
  - *What impact does this have on our identities as therapists or clients?*

How to Explore ‘Subject Positions’ in the Consultation Room

- **Assumptions about basic human needs** determine the positioning of therapist and the client in psychotherapeutic interaction.
- Identifying unmet ‘human needs’ is the core aim of most psychotherapy approaches.
- Assumptions about basic human needs, however, are not universal.
- Different psychotherapy approaches define or emphasize different aspects of human needs.

POSITIONING IN SCHEMA THERAPY (ST)

Early Maladaptive Schemas

- Young developed ST by identifying internalized negative patterns or themes underlying the suffering that bring patients to therapy.
- He organized the themes into 19 distinct early maladaptive schemas (EMS), each implying a **frustrated core emotional need of the child.**
- They represent **adaptations to negative experiences**, for example, family quarrels, rejection, hostility, or even aggression from parents/educators and peers, lack of love and warmth, and inadequate parental care and support.

“Needs” in Schema Therapy

- Needs of the child
  - *Safe Attachment*
  - *Autonomy and Identity*
  - *Realistic Limits and Self Control*
  - *Spontaneity and Play*
  - *Expression of Needs and Emotions*
- Rights of the child

Early Maladaptive Schemas and Needs

Attachment:
- Emotional deprivation
- Abandonment/Instability

Autonomy:
- Dependence/Incompetence
- Failure

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

Expression of Needs and Emotions:
- Approval seeking
- Self Sacrifice

Spontaneity and Play
- High standards
- Punitiveness

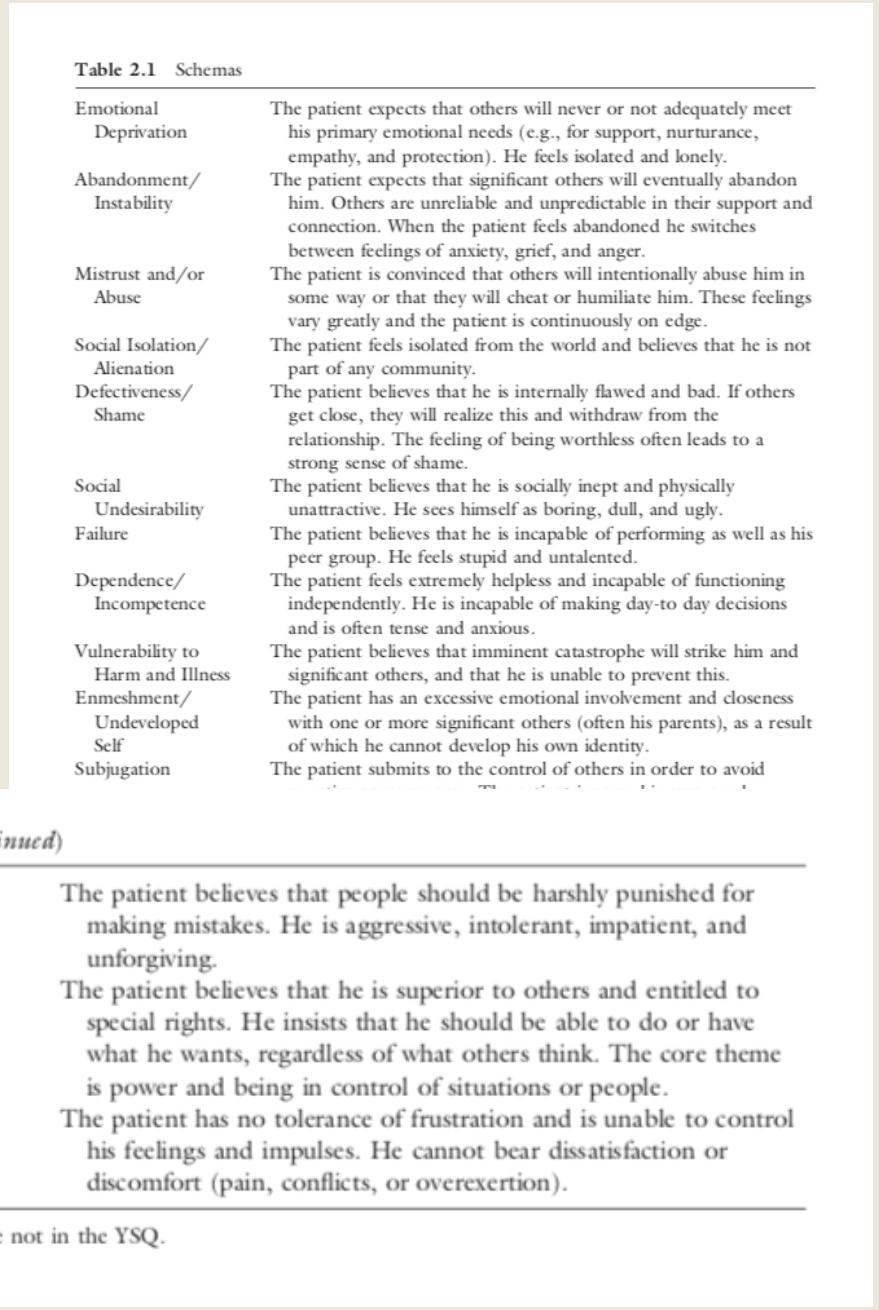

Table 2.1 Schemas

Emotional Deprivation	The patient expects that others will never or not adequately meet his primary emotional needs (e.g., for support, nurturance, empathy, and protection). He feels isolated and lonely.
Abandonment/ Instability	The patient expects that significant others will eventually abandon him. Others are unreliable and unpredictable in their support and connection. When the patient feels abandoned he switches between feelings of anxiety, grief, and anger.
Mistrust and/or Abuse	The patient is convinced that others will intentionally abuse him in some way or that they will cheat or humiliate him. These feelings vary greatly and the patient is continuously on edge.
Social Isolation/ Alienation	The patient feels isolated from the world and believes that he is not part of any community.
Defectiveness/ Shame	The patient believes that he is internally flawed and bad. If others get close, they will realize this and withdraw from the relationship. The feeling of being worthless often leads to a strong sense of shame.
Social Undesirability	The patient believes that he is socially inept and physically unattractive. He sees himself as boring, dull, and ugly.
Failure	The patient believes that he is incapable of performing as well as his peer group. He feels stupid and untalented.
Dependence/ Incompetence	The patient feels extremely helpless and incapable of functioning independently. He is incapable of making day-to day decisions and is often tense and anxious.
Vulnerability to Harm and Illness	The patient believes that imminent catastrophe will strike him and significant others, and that he is unable to prevent this.
Enmeshment/ Undeveloped Self	The patient has an excessive emotional involvement and closeness with one or more significant others (often his parents), as a result of which he cannot develop his own identity.
Subjugation	The patient submits to the control of others in order to avoid

Table 2.1 (*Continued*)

Punitiveness*	The patient believes that people should be harshly punished for making mistakes. He is aggressive, intolerant, impatient, and unforgiving.
Entitlement/ Grandiosity	The patient believes that he is superior to others and entitled to special rights. He insists that he should be able to do or have what he wants, regardless of what others think. The core theme is power and being in control of situations or people.
Insufficient Self-Control/ Self-Discipline	The patient has no tolerance of frustration and is unable to control his feelings and impulses. He cannot bear dissatisfaction or discomfort (pain, conflicts, or overexertion).

* = Schemas that are not in the YSQ.

Early Maladaptive Schemas

- Schemas are more or less active or influential at any one time. When circumstances show similarities with situations that have led to the development of the schema, then that **schema will come to the fore**.
- Maladaptive schemas are often **maintained in adult life because**:
  - *the patient avoids situations that could correct them,*
  - *he is looking for people who will confirm his schemas, and/or*
  - *he has no eye for information that would nuance his schemas.*

Coping Styles

- A person not only has schemas, but also strategies to avoid being bothered by them, hence the coping styles.
- There are three ways in which one can deal with schemas, or coping styles: **Surrender, Avoidance, and Over-Compensation**

Three kinds of coping styles

Proceeding from the Abandonment/Instability schema, someone decides never to enter into a relationship again (avoidance). He thus gains temporary relief, because no one can hurt him by leaving him. However, in the long run, he becomes very lonely, because he avoids all intimacy.

If he decides to compensate for his Over-Compensation schema, he starts looking for the "perfect relationship" with someone who will never abandon him. During the initial period of being in love, he might succeed, but after a while, when the partner wants to have more autonomy, he will claim the other person and demand constant availability. There is a good chance that the partner will not be able to tolerate this and will leave him. This way, the schema is confirmed.

If he submits to the Surrender schema, he settles for a relationship that offers him insufficient support and security (e.g., with a partner who is often unfaithful or a on/off relationship). In a sense, this feels familiar, but in the long run, the patient remains lonely and unhappy.

Modes in ST

- Young (1990) reasoned that the therapist had to offer not only a collaborative adult relationship, as in standard cognitive therapy, but also a **parenting** relationship to the **client's child side.**
- This was needed to help **to correct the dysfunctional schemas** and to allow healthy new schemas to form in the same way that they would have if the clients had a better experience with their own parents.
- This would involve "find out what needs of the child did not get met and try **to meet them to a reasonable degree"**

Modes in ST

- In the development of TA, Berne had emphasized this, adopting the term “ego states” to refer to the **Parent, Adult, and Child** that were central to his model. As he observed, “Parent, adult and child are not just concepts but “**phenomenological realities**”

- Young developed the **concept of schema modes** further as he increasingly experimented with imagery and chair dialogues which bring contrasting parts of the self into focus.

Modes in ST

Child modes	
Vulnerable Child	The patient believes that nobody will fulfill his needs and that everyone will eventually abandon him. He mistrusts others and believes that they will abuse him. He feels worthless and expects rejection. He is ashamed of himself and he often feels excluded. He behaves like a small, vulnerable child that clings to the therapist for help, because he feels lonely and believes there is danger everywhere.
Angry Child	The patient feels intensely angry, enraged, and impatient because his core needs are not being met. He can also feel abandoned, humiliated, or betrayed. He expresses his anger in extreme manifestations, both verbal and nonverbal, just like a small child who has an outburst of anger.
Enraged Child	The patient feels enraged for the same reason as the Angry Child, but loses control. This is expressed in offensive and injurious actions toward people and objects, in the same way as a small child hurts his parents.
Impulsive Child	The patient wants to satisfy his (non-core) desires in a selfish and uncontrolled manner. He cannot control his feelings and impulses and he becomes enraged and infuriated when his (non-core) desires or impulses are not met. He often behaves like a spoiled child.
Undisciplined Child	The patient has no tolerance of frustration and cannot force himself to finish routine or boring tasks. He cannot bear dissatisfaction or discomfort (pain, conflict, or overexertion) and he behaves like a spoiled child.
Happy Child	The patient feels loved, satisfied, protected, understood, and validated. He is self-confident and feels competent, appropriately autonomous, and in control. He can react spontaneously, is adventurous and optimistic, and plays like a happy, young child.

Maladaptive parent Modes	
Punitive Parent	The patient is aggressive, intolerant, impatient, and unforgiving toward himself. He is always self-critical and feels guilty. He is ashamed of his mistakes and believes he has to be punished severely for them. This mode is a reflection of what (one of) the parents or other educators used to say to the patient in order to belittle or punish him.
Demanding Parent	The patient feels that he must fulfill rigid rules, norms, and values. He must be extremely efficient in meeting these. He believes that whatever he does is never good enough and that he must strive harder. Therefore, he pursues his highest standard until it is perfect, at the expense of rest and pleasure. He is also never satisfied with the result. These rules and norms are also internalized by (one of) the parents.
Healthy mode	
Healthy Adult	The patient has positive and neutralized thoughts and feelings about himself. He does things that are good for him and this leads to healthy relationships and activities. The Healthy Adult mode isn't maladaptive.

Maladaptive coping Modes	
Compliant Surrender	The patient devotes himself to the desire of others in order to avoid negative consequences. He suppresses his own needs or emotions and bottles up his aggression. He behaves subserviently and passively, and hopes to gain approval by being obedient. He tolerates abuse from other people.
Detached Protector	The patient cuts off strong feelings because he believes that such feelings are dangerous and can get out of hand. He withdraws from social contacts and tries to cut off his feelings (sometimes this leads to dissociation). The patient feels empty, bored, and depersonalized. He may adopt a cynical or pessimistic attitude to keep others at arm's length.
Detached Self-Soother	The patient seeks distraction in order not to feel negative emotions. He achieves this by self-soothing behavior (e.g., sleeping or substance abuse) or by self-stimulating activities (being fanatical or occupied with work, the internet, sport, or sex).

Positioning in the Consultation Room in ST

- For the client
  - *Child modes*
  - *Parent modes*
  - *Maladaptive coping modes*
- For the therapist
  - *Healthy adult mode*
  - *Limited reparenting*
  - *Advocate of child rights*

POSITIONING IN INTERPERSONAL PSYCHOTHERAPY (IPT)

“Needs" in Interpersonal Psychotherapy

- “IPT is designed to help people recognize their **interpersonal needs for attachment and reassurance**, and to express those needs graciously so that others can respond in a helpful way.”
  - *Need for felt security through interpersonal relationships*
  - *Need for bonding, connections, attachment*
  - *Need for clear communication*
  - *Need for social support*
  - *Need for taking responsibility for generating change within his/her social environment and for making changes in his/her interpersonal relationships*

Attachment Theory, Bowlby

- **John Bowlby** among others articulated the principles of Attachment Theory, which is based on the premise that **humans have an intrinsic instinctual drive to form interpersonal relationships.** This drive is **biologically grounded.**
- Bowlby's concept of a **working model of attachment**: the cumulative experiences of an individual inform the way she relates to others.
- An individual experiences interpersonal problems not because her working models are inaccurate reflections of her past experiences, but because the **models are imposed inappropriately onto current and new relationships**, in which her assumptions about the ways others will behave towards her are not accurate.

Four Quadrant Model of Attachment

- Bowlby described three basic styles of attachment: secure, anxious ambivalent, and anxious avoidant. Over the past decade, this model has been replaced in IPT by **Bartholomew and Horowitz**'s four quadrant model of attachment.
- The four quadrants of this model are the result of the intersection of the **individual's working model of self (x-axis) and working model of relationships with others (y-axis).**

Four Quadrant Model of Attachment

A working model of self as either capable of caring for their own needs for the most part, or as needing to rely on others for care

A working model of others as either dependable – i.e. willing to provide care if asked – or not dependable.

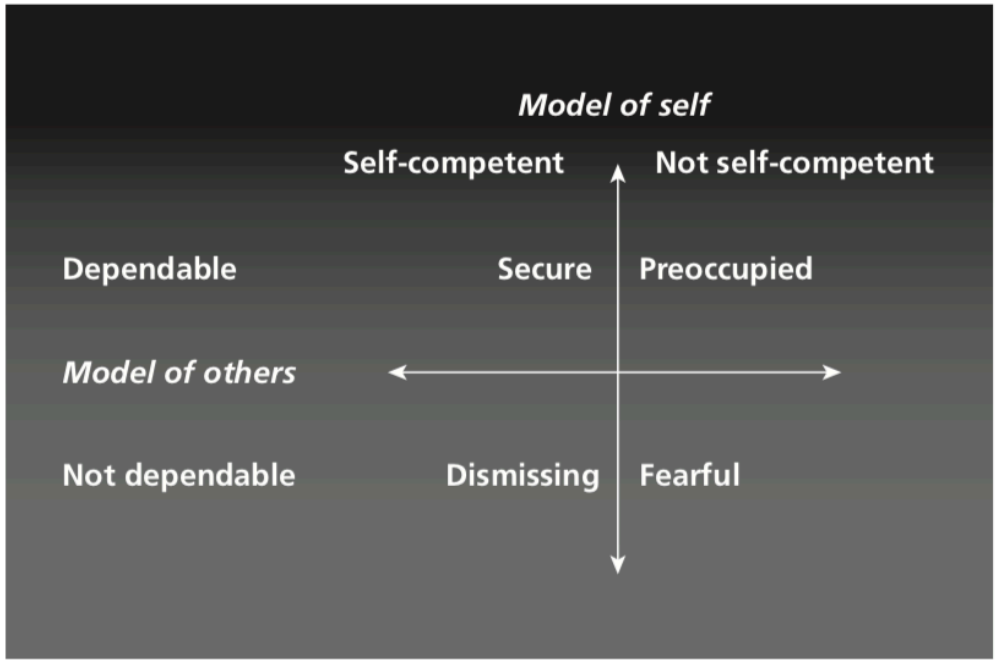

Figure 2.3 The four quadrant model of attachment in IPT

Interpersonal Theory

- Describing the way individuals communicate their attachment needs to significant others within specific interpersonal relationships.
- In every interpersonal communication that occurs, individuals negotiate three specific aspects of relationship:
  - *Affiliation*, i.e. the degree to which individuals have positive or negative feelings about one another
  - *Status*, i.e. the degree to which one or the other person is 'in charge' of decisions made within the relationship and the agenda for the relationship
  - *Inclusion*, i.e. the degree to which the relationship stands as important to each individual

Attachment and Communication

- According to Kiesler, interpersonal problems occur because patients **unintentionally elicit negative reciprocal responses from others**
  - *Hostile aggression, for example, elicits more hostility and rejection.*
  - *Persistent passive-aggressive communication ultimately elicits low-affiliative rejection.*
- Individuals tend to communicate their attachment needs in a consistent fashion over time.
- **Maladaptive attachment styles** are therefore reflected on a micro-level as **specific communications which elicit responses that do not effectively meet the individual's attachment needs.**

Positioning in the Consultation Room in IPT

- For the client
  - *Insecurely attached- preoccupied, dissmissive or fearful*
  - *Inappropriate or inadequate interpersonal communication*
- For the therapist
  - *Securely attached, wise and high in power.*
  - *High degree of inclusion and affiliation for the client*

POSITIONING IN GESTALT THERAPY (GT)

“Needs" in Gestalt Therapy

- **No specific need is identified as the “core need”.**
- **Need is always healthy**
- Need organizes the field
- Need requires satisfaction for growth to occur

- The question is not “what the need is”, but, it is “**how to satisfy the need**”

“Change occurs when one becomes what he is,

not when he tries to become what he is not” Arnold Beisser

Gestalt Cycle of Experience

- Heuristic/diagnostic model known as the **Contact Cycle**, or Cycle of Experience **outlines the life history of an impulse or desire** in GT
  - *sensation and awareness (the **formation of a sense of need**),*
  - *heightening of energy and mobilization, action toward the goal*
  - *"**contact**" in the sense of transaction or resolution,*
  - *Withdrawal, closure, and then on to the next **sensation and need***

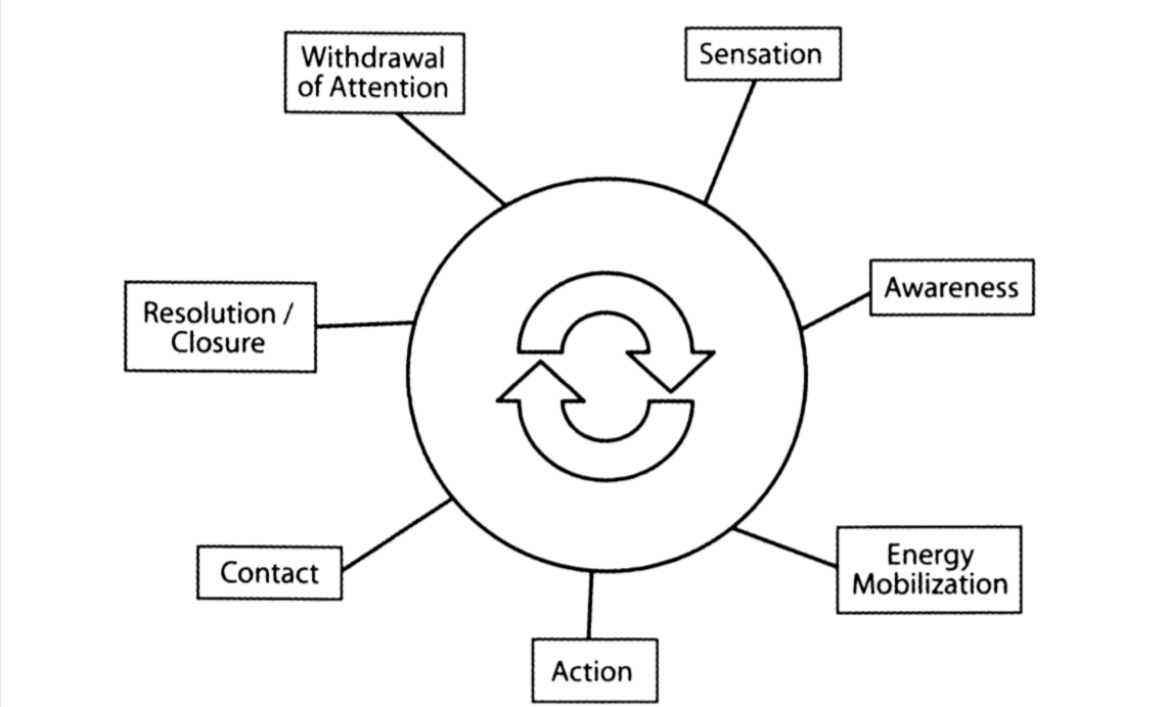

Fig. 1. The "Gestalt Cycle of Experience: Flow of an Uninterrupted Sequence" (from Nevis, 1987, used by permission)

Organismic Self-regulation

- Cycle of Experience sequence is natural and "organismic", basically **biological in nature**; thus, left to itself, it should simply run out to a series of satisfying outcomes
  - *If there were no internal **interruptions** or "resistances",*
- Presumably it also coordinates those goals and paths with the sometimes nested, sometimes contradictory unfolding of other goals by a homeostatic process of "**organismic self-regulation**"

Interruptions

- While good **contact** can be assisted by awareness of contact functions and contact boundaries, it can be **blocked** in many different ways that have been explored in the literature
  - *Confluence, introjection, projection, retroflection, egotism, deflection…*
- They are **creative adjustments** that are **anachronistic:** (belonging to another time, another context)
- They were useful once but now they are fixed and become a part of the **character.**

Interruptions

- **Introjection** involves the **unexamined incorporation of external ideas** into one's mind. Can take the form of commands such as "Be on time," "Be polite," "Work hard," and "Be loyal to the family." Introjectors find it difficult to be spontaneous, since they have swallowed directives which are not their own.
- **Projection** is often considered to be an aggressive approach to the environment in which individuals do not want to recognize certain characteristics in themselves. Projectors **identify their own characteristic in another individual and transfer responsibility** for it onto this person.

Interruptions

- **Retroflection** is defined as “to turn sharply back against”. Retroflectors do to themselves what originally they wanted or tried to do to others or to objects, or what they wanted others to do to them. They **redirect activity inward and substitute themselves as the target of their own behavior**. In full retroflection, the desire to behave in a particular manner is blocked and converted to **muscular tension**.
- **Confluence** is a way of **blending in with others** and avoiding expressing one’s own opinions or wishes. What is going on inside is not separated from what is going on outside. In unhealthy confluence, true interpersonal contact does not occur because there is no boundary between themselves and others.

Interruptions

- **Deflection**, is a "**manoeuvre for turning aside from direct contact** with another person. The heat is taken off by circumlocution, by excessive language, by laughing off what one says, by not looking at the person one is talking to, by being abstract rather than specific, by politeness instead of directness, by substituting mild emotions for intense ones, by talking about the past when the present is more relevant, by talking about rather than to, and by shrugging off the importance of what one has said"

Positioning in the Consultation Room in GT

- For the client
  - *Self regulating organism going through cycle of experience*
  - *Blocked in awareness for contact because of interruptions*
- For the therapist
  - *Another self regulating organism going through cycle of experience*
  - *Built awareness on interruptions (of himself and the client) and knowledge/experience on how to frustrate these interruptions*

COMPARISON OF THERAPY APPROACHES

	Unmet Needs	Main Concepts	Positioning of the Client	Positioning of the Therapist	Focus is on
ST	Safe attachment, Autonomy, Clear limits, Spontaneity, Emotional expression	Early maladaptive schemas, Coping styles, Modes	Displaying child modes, parental modes or maladaptive coping modes	Healthy adult, Limited reparenting role, Advocate for the "child rights"	Unmet needs of the past that effect the present of the client through EMS
IPT	Safe attachment, Clear communication, Social support	Working model of self and the other, Attachment style, Communication style	Insecurely attached, Having maladaptive communication styles	Securely attached, wise and high in status, Having high affiliation and inclusiveness for the client	Unmet needs of the past that effect the present of the client through maladaptive attachment and communication style
GT	Needs are always healthy.	Cycle of experience, Organismic self regulation, Creative adjustments	Self regulating organism going through cycle of experience for need satisfaction, Displaying interruptions for the contact	Self regulating organism going through cycle of experience, Building awareness on interruptions and how to frustrate them	Needs of the present that cannot be fully satisfied because of anachronistic creative adjustments

What’s Next

- Study of positionings of clients and therapists in **lived practice** through conversation analysis, discourse analysis or narrative analysis.
- Attention on **storylines** of clients and therapists in the consultation room for understanding self and other positionings.
- Increasing awareness of therapists for the effects of self and other positionings on the **therapeutic work**.