

# Instruction Guide for Schema Therapy Case Conceptualization Form

**2<sup>nd</sup> Edition**  
Version 2.22

## Overview

The purpose of this form is to guide you in obtaining the basic information you need from the assessment phase of your work with the patient, so that it can serve as your case conceptualization. It is recommended that you return to this form as the therapy progresses and update it with additions or modifications as new information comes to light.

At times you may find that you feel as if you are being asked to repeat the same information in different parts of the form. When this happens, there is no need to repeat the details. You can simply refer back or forward to the particular section where the material has already been presented.

If you want to include more information, you can add additional pages for any answer, comment at the end of the form, or extend any of the sections.

**Therapist's Name:** Name of the therapist treating the patient & filling out this form

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

**Number of Sessions:** Number of sessions including the patient's first session

**Months since 1<sup>st</sup> Session:** Number of months since the patient's first session

## I. Patient Background Information

**Patient's Name/ID:** The patient's name, pseudonym, or identification code

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

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

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

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

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

## II. Why is the Patient in Therapy?

What are the primary factors motivating the patient to come for treatment? What aspects of the patient's life circumstances, significant events, symptoms/disorders, or problematic emotions/behaviors are contributing to his/her problems (e.g., health problems, relationship issues, angry outbursts, anorexia, substance abuse, work difficulties, stage of life)? Discuss the reason(s) the patient *initially* came to therapy and why he/she is coming to therapy *currently*. Is the patient coming voluntarily? How high is the patient's current level of distress?

## III. General Impressions of the Patient

Using everyday language, briefly describe how the patient comes across in a global sense during sessions (e.g., reserved, hostile, eager to please, needy, articulate, unemotional). Please answer these questions in relation to the *initial* as well as *current* sessions. Note that this item does not include a discussion of the therapy relationship or change strategies.

## IV. Current Diagnostic Perspective on the Patient

### A. Main Diagnoses: (include name & code for each ICD-10-CM disorder)

List up to 4 psychiatric diagnoses that apply to the patient, drawn directly from ICD-10-CM. For each diagnosis, include both the *name and numeric code*.

Click on this link to download an extensive PDF file containing the *original ICD-10 psychiatric codes, with their official names and detailed diagnostic guidelines* (pages 40-228): <http://www.who.int/entity/classifications/icd/en/bluebook.pdf?ua=1>

For an online, *up-to-date* listing of the ICD-10 codes and names, *without diagnostic criteria*, click on the link below (Section V):

<http://apps.who.int/classifications/icd10/browse/2016/en#/F30-F39>

### B. Current Level of Functioning in Major Life Areas

Rate the patient on each of the 5 life areas in the table below, using the 6-point scale below. Briefly explain your rationale for each rating.

#### Overview. *Current Level of Functioning* defined

*Current Level of Functioning* is defined as the quality of the patient's current overall behavior in each individual life area. This should generally be rated from the perspective of an *objective* observer – *not* subjectively. Furthermore, your ratings of the patient should be in comparison with the "general public," *not* relative to other patients or to some ideal person.

#### Column 2. Rating Scale for *Level of Functioning*

In the 2<sup>nd</sup> column, use the 6-point scale below to rate the patient's *current level of functioning* for each of the five major life areas listed in Column 1.

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

If there are circumstances beyond the patient's control that make a specific life area inappropriate to rate (such as age or a recent loss), write N/A (*Not Applicable*) in Column 2 -- then explain why in Column 3.

### Column 3. Explanation or Elaboration

In the 3<sup>rd</sup> column, briefly explain why you rated the patient as you did, for each major life area.

If there is a significant discrepancy between the patient's previous and current levels of functioning, elaborate on the change. *Example:* The patient had excellent relationships with friends prior to the onset of a major depression.

### Expanded descriptions of the 5 Life Areas:

To clarify the differences, we have provided expanded explanations of the 5 life areas below:

- **Occupational or Educational Performance:** Refers to how well the patient is functioning at work or in school, relative to both what is considered "normal" for the patient's age and peer group; and to what the patient is probably capable of (based on ability and background).
- **Intimate, Romantic, Longer-Term Relationships:** Refers to *stable, relatively long-term* relationships with *intimate* partners. These relationships involve a romantic/sexual component during at least some periods. Examples would include marital or similar committed relationships; and other longer-term partners. Short-term dating relationships or "friends with benefits" do *not* qualify for this category.
- **Family Relationships:** Refers to the patient's relationships with family members, including their own children, parents, grandparents, siblings, and other extended family members (e.g., uncles, cousins, nieces, in-laws). This category does not include romantic partners, such as husbands, "live-in" partners, dating relationships, etc.
- **Friends & Other Social Relationships:** Refers to most other types of ongoing social relationships not mentioned above. Special emphasis should be placed on current relationships with friends and, to a lesser degree, work colleagues. Short-term dating relationships, or "friends with benefits", can be included in this category. Involvement in other social relationships -- such as neighbors, community members, and clubs -- can also be included in your rating.
- **Solitary Functioning & Time Alone:** Refers to the patient's current level of ability to find healthy meaning, focus and stimulation when alone. This includes the capability to manage thoughts and feelings in a healthy way when alone. This rating should also include the patient's ability to perform activities of daily living independently (e.g. personal hygiene, housekeeping activities, etc.).

## V. Major Life Problems & Symptoms

*In order of importance*, list at least 3 current, major life problems or symptoms/disorders. Then, elaborate on the nature of the problem, and how it creates difficulties in the patient's current life. Try to avoid schema terminology in each problem or symptom

If you list a psychiatric symptom, it should be related to one of the diagnoses in Section IV.A. above. If you prefer, you can list more than one symptom as 1 of the problem areas, if they relate to the same psychiatric diagnosis. (For example, you could list: *Recurrent Depressive Disorder: loss of interest in anything, tired all day, can't concentrate on work, disturbed sleep.*) Then you should elaborate on the nature of the symptoms and describe how they create difficulties in the patient's current life.

## VI. Childhood & Adolescent Origins of Current Problems

### A. General Description of Early History

Summarize the important aspects of the patient's childhood and adolescence that contributed to his/her current life problems, schemas, and modes. Include any *major problematic/toxic experiences or life circumstances* (e.g., cold mother, verbally abusive father, scapegoat for parents' unhappy marriage, unrealistically high standards, rejection or bullying by peers).

### B. Specific Early Core Unmet Needs

For Questions 1-3 below, specify the most relevant of the patient's core unmet needs. Then briefly explain how specific origins from section VI. A. above led to the need not being met. You can also use the YPI, the patient's self-report, family sessions (when feasible), and imagery assessment exercises to obtain this information. For Question 4, list other early unmet needs that are less relevant than the ones in Questions 1-3.

### C. Possible Temperamental / Biological Factors

List facets of temperament – and/or biological factors – that may be relevant to the patient's problems, symptoms & the therapy relationship.

Although you may use other descriptive words, it is sufficient just to list adjectives from the list below that you believe are part of the patient's basic temperament or "nature", rather than situation-specific.

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

Also include any biological factors that may have played a significant role in schema or mode development (e.g., height, medical conditions, autism, etc.).

#### **D. Possible Cultural, Ethnic & Religious Factors**

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

### **VII. Most Relevant Schemas (Currently)**

For Items 1-4, select the schemas that are *most central to the patient's current life problems*. First specify the name of the schema. Then describe how each schema plays itself out currently. Discuss the specific type of situation in which the schema is activated and describe the patient's reactions. What negative effect(s) does each schema have on the patient? List any other relevant schemas in Item 5.

### **VIII. Most Relevant Schema Modes (Currently)**

#### **Sections A. – C.**

For Items 1-6, select the modes that are most central to the patient's current life problems. First label the mode (e.g., Lonely Child, Self-Aggrandizer, Punitive Parent). Then explain how this mode plays itself out currently. What types of situations activate the mode? Describe the patient's behaviors and emotional reactions. Which schema(s) often trigger the mode? What negative effect(s) does each mode have for the patient? (If a mode does not apply to the patient, leave it blank. You can add additional modes in Section D.) Under other child modes you can include the Contented/Happy Child, if relevant.

#### **Section D. Other Relevant Modes (Optional)**

You may find that you want to add *additional* modes, or subtypes of modes, but have run out of space in Sections A – C above. If so, you can add 1 or 2 *Other Modes*. These modes can be Child Modes, Coping Modes, or Dysfunctional Parent modes. Be sure to specify which category each of the "Other Modes" relates to (e.g., *Child mode: Angry Child; Coping mode: Approval-Seeking*).

#### **Section E. Healthy Adult Mode**

For the Healthy Adult Mode, describe the patient's Positive Values, Resources, Strengths, & Abilities. For example, you could discuss positive indicators for therapeutic progress; resources such as family members and social support; meaningful life goals; personal values; sources of vitality, passion, inspiration, commitment; and other strengths.

## IX. The Therapy Relationship

### A. Therapist's Personal Reactions to the Patient

Describe the therapist's *positive & negative reactions* to the patient. What patient characteristics/behaviors trigger these personal reactions? What therapist schemas and modes are activated? What impact do the therapist's reactions have on the treatment?

Based on the assumption that each patient elicits a specific and unique set of reactions from the therapist, identifying these reactions can cultivate self-awareness in the therapist, and can inform the therapist about the patient. Understanding these personal reactions can guide the therapist so that negative reactions do not interfere with the therapy process.

### B. Collaboration on Therapy Objectives & Tasks

#### Overview

#### a. Definition of *Therapy Collaboration*

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

#### b. In-Depth Example of *Therapy Collaboration*

The therapist and patient have been able to agree on objectives that are important to the patient, and the patient is enthusiastic about reaching these goals. There is an easy dialogue in working out what is best to discuss and explore from session to session, and the patient appears willing to explore interpersonal issues. However, the patient often misses appointments or needs to change the appointment time. This seems inconsistent with the enthusiasm expressed in session, and with the relatively undemanding circumstances of the patient's life. The patient completes homework approximately 50% of the time; and the reasons given for not completing homework are often not convincing.

### **Item 1. Rating for *Collaboration on Objectives & Tasks***

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

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

### **Item 2. Briefly describe the collaborative process with this patient.**

What positive and negative factors/behaviors serve as the basis for your rating in 1 above?

Describe the ways in which the patient and therapist have worked together that have been positive and negative. Examples include the degree to which there is a sense of shared understanding; agreement on strategies and objectives; and an ability to work out conflicts. Also, describe the specific ways in which the therapist interacts with the patient that promote a positive collaboration

### **Item 3. How could the collaborative relationship be improved?**

What changes could the therapist and patient make to bring this about?

Focus on the kinds of barriers that make collaboration difficult. These could include chronic misunderstandings; lack of agreement about techniques or objectives; passive-aggressive behavior; failure to complete homework; missed sessions; and anger toward the therapist. Also, describe the specific ways the therapist interacts with the patient that undermine a positive collaboration and the ways that the therapist could remedy these collaborative problems.

## C. Reparenting Relationship & Bond

### Overview

#### a. Definition of the *Reparenting Relationship & Bond*

The Reparenting Bond refers to the level, depth & type of attachment and bonding between the therapist and patient. The *Reparenting Relationship & Bond* includes the ways in which the therapist attempts to meet the patient's core needs (demonstrating such characteristics as warmth, acceptance, non-verbal expressions of caring, validation, and promoting autonomy) – in addition to the patient's receptivity to Limited Reparenting. The patient's responses to these attempts at Reparenting need to be assessed and described in order for the therapist to adapt the Reparenting Relationship in future sessions.

#### b. In-Depth Example of the *Reparenting Relationship & Bond*

The therapist often attempts to validate the pain and suffering the patient feels in relation to current concerns. But these attempts are usually met with the patient minimizing or denying any need for validation. When the therapist demonstrates empathic understanding of the confusion and uncertainty the patient feels regarding his/her current circumstances, the patient usually just stares blankly back at the therapist. This reaction changed recently when the patient's eyes sometimes glistened with tears, and the patient began to lean forward toward the therapist. The patient has been encouraged to call between sessions if they need to talk, especially since a new interpersonal crisis has arisen. The patient has made a "check-in" call once, but with apologies for interrupting the therapist's life. The reparenting bond is currently tentative, and reflects a cautious attachment. It is unclear whether the therapist's behavior during sessions is somehow contributing to the difficulty in creating a more secure reparenting bond.

#### Item 1. Rating of the *Reparenting Relationship & Bond*

Rate the depth of the *Reparenting Relationship & Bond* based on the patient's behaviors and emotional connection, both in sessions and outside of sessions. Use the following 5-point Rating Scale:

- 1 = VERY WEAK, MINIMAL Reparenting Bond (e.g., mostly detached and uninterested/non-acknowledging of the therapist; body language and eye contact show no apparent bond; very impersonal; may seem angry or critical of the therapist)**
- 2 = WEAK (e.g., rarely emotionally present; makes some eye contact; will discuss issues but with little affect; "business-like" relationship with the therapist)**
- 3 = MODERATE (e.g., occasionally interested in the therapist and the therapist reactions/opinions; sometimes shares personal reactions to the treatment and shows some vulnerability)**



**4 = STRONG (e.g., often shows vulnerability and risk-taking with the therapist; engages with the therapist much of the time; expresses clear evidence of an emotional attachment; seems to value therapist's caring & help; contacts therapist outside of sessions when appropriate)**

**5 = VERY STRONG Reparenting Bond (e.g., consistently seems vulnerable and trusting of the therapist; able to express positive feelings about the therapist and the therapy; connects to the therapist like a parent-figure, family member, or close friend)**

**Item 2. Briefly describe the *Reparenting Relationship & Bond* between the patient and therapist.**

Elaborate on the *patient's* behaviors, emotional reactions and statements in relation to the therapist that serve as indicators of how strong (or weak) the reparenting bond feels for the patient.

**Item 3. How could the *Reparenting Relationship & Bond* be improved or strengthened?**

Which unmet needs could the therapist fulfill more deeply or completely? What specific steps could the therapist take to make the bond stronger for the patient?

**D. Other Less Common Factors Impacting on the Therapy Relationship (*Optional*)**

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

**X. Therapy Objectives: Progress & Obstacles**

List the most important therapy objectives. Be as specific as possible. Then, for each objective, discuss the modes and schemas to target, the progress thus far and describe any obstacles. Also, describe how the healthy adult mode could be changed to meet each objective. You can add additional objectives in Item 5. (Objectives can be described in terms of: schemas, modes, cognitions, emotions, behaviors, relationship patterns, symptoms, etc.)

**XI. Additional Comments or Explanations(*Optional*)**

Please add any additional information -- or clarify any of your answers above -- to help your supervisor or rater better understand your conceptualization of the patient, the therapy relationship, and progress in therapy. Feel free to add more pages if you want to.

