

What Schema Therapy Offers

1.1 What is Hidden, What is Seen

For couples, the most common clashes are around the “rough edges” of personality. Indeed, there is a great silence in relationship therapy about the influence of personality disorders. Research has established that such traits are very common. Only 23 percent of the general population is relatively free of them; over 70 percent of people “have some degree of personality disturbance” (Yang et al., 2010).

It makes sense that character traits will cause relationship difficulties. We are attracted to a *personality* but live with a *character*. If there are long-term character problems, which is another way of describing personality vulnerability, then relationship difficulties are inevitable.

Richard had a history of many short-term relationships, which were perhaps more sexual “flings” to avoid boredom. He would leave when lovers became more “needy”. He had been sexually abused as a child and never experienced warmth or protection by a parent or step-parent. He knew only criticism. Eventually, he married Carol because he wanted a stable relationship to raise children. When he had an affair, it was devastating to his wife. It was hard to even talk issues through because Richard avoided conflict. A lot was happening in this relationship that was far from obvious.

Some couples deny any problems, even to the point of separation and divorce, but there is a long history of hidden clashes underlying the deterioration of their relationship.

2 *Schema Therapy with Couples*

Reflect: What has been your most difficult couple to treat? Why? Do you recognize possible traits of personality disorder?

1.2 Listening to the Evidence

There is currently a crisis in relationships, and couples commonly present for therapy. So why not simply use the available evidence-based treatment for relationships? The answer is not straightforward. There is good research. John Gottman (1999) has contributed enormously to what we know through his “Love Lab.” He has provided years of longitudinal data on couple processes. This includes easy-to-understand principles thoroughly grounded in extensive research. This can inform our practice. While Gottman and his colleagues have not yet produced randomized controlled trials, his work would meet the criteria of the American Psychological Association’s policy statement on evidence-based practice in psychology: “the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences” (see APA, 2006).

Sexton and Gordon (2009) distinguished three levels of evidence:

1. evidence-informed interventions based on pre-existing evidence
2. promising interventions, but preliminary results not replicated
3. evidence-based treatments with systematic high-quality evidence demonstrating efficacy with clinical problems that the interventions are designed to address.

There is some Level 3 support for behavioral marital therapy (Jacobson & Margolin, 1979), cognitive behavioral marital therapy (Baucom & Epstein, 1990), integrative couple therapy (Jacobson & Christensen, 1996), and emotion-focused therapy for couples (EFT-C; Greenberg & Goldman, 2008).

In our experience, EFT-C works with many, and perhaps most, couples. But there is no specifically evidence-based therapy for couples with personality disorder (or for couples with strong traits, even if not diagnosed). What exists is evidence of the effectiveness of *individual* treatment for individuals with personality disorder, initially borderline personality disorder (BPD). It makes clinical sense that difficult couples may need an enhanced approach with ST or dialectical behavior therapy (Linehan, 1993). Both employ stronger interventions aimed at changing ingrained aspects of character. A 2010 review concluded that

dialectical behavior therapy has Level 3 and ST has Level 2 evidence for effectiveness with adults diagnosed with BPD (APS, 2010, p. 112). A study of ST treatment of BPD inpatients using groups has reported large effect sizes (Farrell & Shaw, 2012), and a study has recently indicated the effectiveness of ST with other personality disorders (Bamelis et al., 2014).

We believe that ST has significant advantages over dialectical behavior therapy,² so applying ST to working with couples (schema therapy for couples, ST-C) is the focus of this book. We hope that it may prove to have some of the strengths already demonstrated by ST case conceptualization and interventions in individual and group therapy.

1.3 Beyond Just Cognitive Therapy

One of the strengths of ST is its origins in cognitive therapy, which has the advantage of conceptual clarity and ease of understanding. Now, in the twenty-first century, it incorporates a good deal more than talk. This includes both non-verbal cognitions (imagery) and embodiment techniques (Rosner et al., 2004). It is essentially integrative.

Aaron Beck (1963) initiated the “cognitive revolution” and developed what is now extensively researched cognitive behavioral therapy for the treatment of depression. This approach was then applied to the whole range of psychological disorders. But cognitive behavioral therapy did not prove as effective with the personality disordered, which led to “third wave” therapies, including dialectical behavior therapy and ST.

While Beck referred to schemas, it was more in the sense of clusters of negative beliefs about the self. A similar understanding of schemata is found in the work of Theodore Millon, in which patterns of dysfunction are foundational to personality disorder (Millon, 1990, p. 10). Jesse Wright and colleagues followed in this approach and noted that people typically have a mix of different kinds of schemas: “even patients with the most severe symptoms or profound despair have adaptive schemas that can help them cope ... efforts to uncover and strengthen positively oriented beliefs can be quite productive” (Wright et al., 2006, p. 174).

² Dialectical behavioral therapy, while effective, is essentially a “here and now” cognitive therapy. It also makes the assumption that a “wise mind” or “healthy adult” is always available, while ST deals with that not being the case. ST also goes to the developmental origins of adult problems, to effectively “repair” experiences of neglect and trauma through imagery work embedded in a re-parenting relationship.

1.4 Jeff Young and the Development of Schema Therapy

ST was developed from cognitive therapy as a means of treating difficult people. Jeffery Young et al. (2003) linked maladaptive schemas to neglect and toxic childhood experiences. They reflect the unfulfilled yet important needs of the child and represent adaptations to negative experiences, such as family quarrels, rejection, hostility, or aggression from parents, educators or peers, as well as inadequate parental care and support (van Genderen et al., 2012). This approach has more of an emotional focus and a willingness to explore the childhood/adolescent origins of psychological problems.

Young identified a comprehensive set of early maladaptive schemas, which were defined as “self-defeating emotional and cognitive patterns that begin early in our development and repeat throughout life” (Young et al., 2003, p. 7). Schemas are identified by clinical observation (Arntz & Jacob, 2013). The expression of such patterns has different levels of severity and pervasiveness. The idea of schema *activation* is fundamental to an understanding of Young’s contribution. A more severe schema is distinguished by how readily it is activated, the intensity of affect and how long distress lasts (Young et al., 2003, p. 9).

ST provides a blueprint for the child and later adult’s world. While schemas might have had some survival value for the child (Kellogg, 2004), by adulthood they are “inaccurate, dysfunctional, and limiting, although strongly held and frequently not in the person’s conscious awareness” (Farrell & Shaw, 2012, p. 9).

Young et al.’s (2003) understanding of schemas drew on a variety of sources. Indeed, they outlined parallels and differences with major approaches, including Beck’s “reformulated” model, psychoanalytic theory, Bowlby’s attachment theory (especially internal working models), and emotion-focused therapy (EFT). ST has integrated techniques adapted from transactional analysis and gestalt therapy (Edwards & Arntz, 2012). Jeff Young (2012) also described ST as an individual therapy with systemic implications. There is a breadth, applicability and ease of understanding that encourages a broader application.

Young (1999, p. 20) also identified needs of childhood in five “domains,” which can be seen as five tasks for therapy:

- connection and acceptance
- autonomy and performance
- realistic limits
- inner-directed ness and self-expression
- spontaneity and pleasure.

1.5 The Schema Model

Young identified the following 18 schemas: Abandonment (instability), Mistrust-Abuse, Emotional Deprivation, Defectiveness-Shame, Social Isolation (alienation), Dependence Incompetence, Vulnerability to Harm or Illness, Enmeshment (undeveloped self), Failure (to achieve), Entitlement Grandiosity, Insufficient Self-control (or self-discipline), Subjugation, Self-Sacrifice, Approval Seeking (recognition seeking), Negativity Pessimism, Emotional Inhibition, Unrelenting Standards (hyper-criticalness), and Punitiveness. Maladaptive schemas hinder people from recognizing, experiencing, and fulfilling their own needs (Arntz & Jacob, 2013).

Reflect: You can think about schemas as patterns of vulnerability, or as domains in which emotional learning took place in childhood.

Young also looked at patterns of response to schema vulnerability, including surrender, avoidance, and compensation leading to specific coping behavior. The 18 maladaptive schemas are very comprehensive, especially when coupled with three response patterns. However, there are potential treatment difficulties:

1. *Complexity.* The whole list of the schemas with response patterns is potentially 54 different schema-coping presentations. While most people may only have a few schemas with characteristic response patterns, more disturbed people, such as those with BPD, typically will be troubled by many schemas. This leads to considerable complexity.
2. *Instability.* The relative instability of low-functioning clients adds another layer to the difficulty. In a session, there may be frequent “flipping” between various schema activations and coping behaviors, which the therapist needs to track. These difficulties led to the development of *modes* to describe schema activation in the “here and now” of treatment.
3. *Couple interaction.* Volatile couples present in ways even more unstable than the same people in individual therapy. Thus the intensity of reactions, more frequent flipping in sessions and difficulty tracking changes make up a real therapeutic challenge. Since modes (defined in Section 1.6) are “what you see,” the changing states can be seen and interventions used to target what is happening in the here and now of the session.

However, it is very useful for a therapist to keep thinking in terms of schemas. This provides a very useful clinical context. It is the “depth picture” behind the more obvious presentation of modes.

1.6 Introducing the Mode Model

When Young started working with severely disturbed lower functioning borderline clients he soon found that his schema model was too complicated, so he searched for a different conceptualization. He described the triggering of a schema—its activation, which he called a “mode” (initially called “modus” or “schema states”). So modes are the way schemas appear. A mode can also be the expression of multiple schemas and incorporate different coping styles (van Genderen et al., 2012). The number of possible reactions to schema activation is unlimited.

We do not actually see a schema, but only the activation in the here-and-now of experience (Kellogg & Young, 2006; Roediger, 2012b, p. 3). Recognizing modes helps a therapist to see the “action.” Thus, a mode is a transient expression of schema vulnerability. This includes the emotional, cognitive, and behavioral dimensions of personality (which are further integrated in ST; Farrell & Shaw, 2012). While you *have* a schema; you *are in* a mode.

The major groups of modes are as follows (see Figure 1; for details of the mode model, see Section 6.2):

1. *child modes*, which are regarded as an activation of body systems, such as attachment and self-assertiveness leading to basic emotions

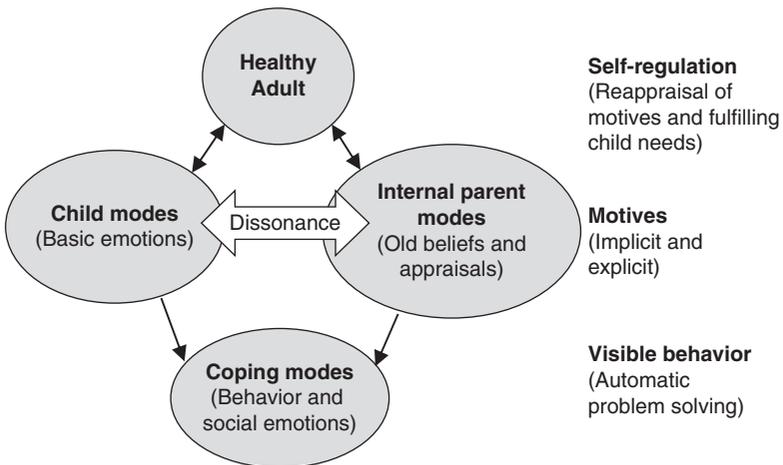


Figure 1 Basic mode model

2. *internalized parent modes*, which preserve the messages, beliefs and appraisals the child heard since infancy
3. *maladaptive coping modes*, which present as visible behaviors resulting from the interaction of child and parent modes, including social emotions
4. *healthy modes*, which are the integrative and adaptive modes “Healthy Adult” and “Happy Child.”

ST sees adult interpersonal problems as the result of negative schemas fixed in childhood. The schemas remain more or less unchanged. Once triggered, they revive the same feelings, appraisals, and tendencies to react as in a distressed child. You might liken it to a person who steps into a time machine and then returns to childhood to a similar reaction. The adult becomes the child again. Hence, this state is called a *child mode*.

The activation of a child mode indicates that a core need has not been met (The exception is the Happy Child mode). Usually, the person keeps seeking some fulfillment. In this way, child modes have a signal character.

Young proposed that a schema therapist respond with “limited re-parenting.” This intervention may differ from what is proposed by therapies that discourage any dependence upon the therapist. But when the child’s needs are more consistently met, first by our re-parenting and then by the client’s own Healthy Adult mode, and possibly later by the Healthy Adult mode of their partner, the client will grow stronger. This is the result we seek through both individual and couples ST.

Reflect: Do you think this might parallel attachment theory? The assumption, from an attachment perspective, is that securely attached children become more autonomous.

Vera had a traumatic childhood in which she was neglected by an alcoholic single mother. An uncle repeatedly sexually abused her. She had a disturbed attachment with her mother, and her schema therapist identified a number of schemas, including Abandonment, Mistrust-Abuse, Emotional Deprivation, Dependence, Defectiveness- Shame and Subjugation. The therapist found her highly unstable in sessions. Vera kept changing between activated modes (what is called “flipping”), and it seemed at times that her distressed states were fed into by a number of schemas. So the therapist used a mode conceptualization to focus on the states that were being fed by the schemas. This made it simpler for her to keep track of how to relate to Vera and help, and also to help Vera understand herself. In early sessions, Vera was mostly in Vulnerable or Angry Child modes, and regardless of which schema or schemas were putting her in those modes, that was what needed to be attended to there and then. The therapist also tried to keep Vera more in the

Vulnerable Child mode so she could get at her unmet needs—reversing the emotional legacy of childhood. This also helped her to attach to the therapist as a parenting source. Later, this led to Vera being able to allow her partner to meet her needs in a healthy way.

Therapy Tip: Once a schema is activated, the person may be in a child mode. In this state, a client should be addressed gently, as we would speak with children. Child-related needs should be met through reassurance, affirmation, empathic limit-setting, blocking a parental mode, and so on.

In summary, a schema is a trait—a tendency to react. A mode is a mental state. As long as schemas are not activated, they remain in the background. Once activated, schemas appear as constantly changing states called modes. We cannot work directly with schemas, only with activated schemas, or modes. This helps case conceptualization because it integrates what is seen with potential interventions to enable an effective treatment plan (van Genderen, 2012). We introduce some helpful resources, such as the mode map in Section 8.2.

Therapy Tip: Try to introduce the mode model early in therapy, usually within the first two or three sessions (Arntz & Jacob, 2013).

1.7 The Challenge of Working with Couples

How does this help us to understand couple relationships? Schemas and modes help to provide a comprehensive framework for understanding relationship dynamics. If a person wants to understand their own relationship, or when we are working in individual therapy, then perhaps the complexity of focusing on individual schemas is less challenging than for a couple. Indeed, some schema problems are relatively straightforward (for example, working with Enmeshment, which might be focused on a single relationship). If this is the case, it might be easiest to work with a single schema related to a specific difficulty.

Natalie brought Sigmund to couple therapy. She had discovered an affair that he had kept hidden for over 12 months. She wanted to understand the vulnerability in their relationship: “Why did this happen?” Sig was contrite and wanted to recommit to his marriage. Through ST-C, Natalie faced her schema vulnerability of Emotional Inhibition and Unrelenting Standards. Sig saw his actions in terms of an Entitlement schema. Both had influential childhood experiences, which were addressed through re-parenting imagery. Behavioral pattern breaking was very important in rebuilding trust.

However, understanding modes enriches the entire experiential process for both individuals and couples in therapy. It reduces the complexity of the schema interactional cycles for couples. Working with modes is usually the most practical way to do ST-C, because it allows a here-and-now approach to the current interaction by demonstrating the clash between modes, sequencing the mode cycle and the common elements of unmet “needs” without being flooded by unnecessary detail early in therapy. Working with modes provides direction and immediate gains in couple sessions.

1.8 Limited Professional Literature

Not much has been published in relation to schema work with couples. A somewhat dated review of the cognitive literature was provided by Wisman and Uewbelacker (2007) in their chapter “Maladaptive schemas and core beliefs in treatment and research with couples.” The focus on schemas was cognitive, at best providing a review of cognitive behavioral therapy and attachment with some cognitive measures, but there was almost nothing that could be considered creative or cutting edge in terms of treatment. The authors concluded that “no published studies to date have evaluated the efficacy of cognitive therapy specifically devoted to modifying maladaptive schemas or core beliefs” (Wisman & Uewbelacker, 2007, p. 216).

Travis Atkinson (2012) contributed a chapter in the more recently published *Wiley-Blackwell Handbook of Schema Therapy* (van Vreeswijk et al., 2012a). He argued that ST provides “an expansive compass to help the couple’s therapist assess and differentiate core maladaptive themes underlying relationship distress” (Atkinson, 2012, p. 323).

Reflect: What have you always wanted in a therapy for couples?

ST offers the following:

1. *Language.* ST uses an easily understood language of patterns in the self and in relationships. Key concepts such as schemas, coping styles, and modes are easy to understand. Indeed, the ideas are close to a commonsense psychology. The concepts educate and make sense of past experiences for people—and open the door to allow them to speak freely about what they presently feel is relevant.
2. *A focus on the difficult.* Hard-to-treat personality disorders are the normal focus and are not treated as exceptional cases.
3. *Effective interventions.* There are powerful techniques, such as imagery work related to limited re-parenting, chair-work to address core beliefs

in an experiential way, and behavioral pattern breaking. There are important ideas about transforming schemas and strengthening the Healthy Adult mode, and guidance in how to more effectively communicate with a partner who is stuck in a child mode. In this way, ST can realistically address the most problematic aspects of interpersonal behavior and allow us to understand it in terms of prior interpersonal experiences.

4. *Influence of the past.* In ST, the therapist has techniques to counter the past when it intrudes on current relationships. This approach can enhance family-of-origin work, taking the burden off the present relationship so the couple can make a new start in therapy without the legacy of unresolved issues from childhood. You can find an effective balance of couple and individual sessions so that progress can be maintained.
5. *Progress with individuals.* It is even possible to do considerable work “solo” to improve the relationship without the participation of a partner. By including dialog and even limited schema/mode conceptualization about the absent partner in individual therapy, the scope is broadened beyond presenting problems. The therapist can work with the individual on all of their schema vulnerabilities, even those triggered by the relationship, and blind spots in therapy are reduced. Couples and marital work can even have significant accomplishments with this one-person scenario. Even one session with the unengaged partner can have benefit and provide a wealth of data for the therapist working with the other in the schema model.

The relationship or marriage is a combination of two people. When one partner changes their behavior, the relationship changes. ST is not wasted work, even if the couple separate, because it can provide a more solid foundation for future relationships.

6. *Needs.* The therapist will fulfill core needs in counseling and provide a model for functional self-disclosure and the communication of needs. This modeling of a Healthy Adult can be learned by the couple.
7. *Integrative process.* The experiential techniques applied in ST integrate cognitive, emotional, and behavioral changes in one therapeutic process. Functional behavior is enhanced by healing early maladaptive schemas.

ST offers more than technical eclecticism. There is a deep “assimilative integration” (Messer, 2001) of different perspectives and insights

from various schools into a system of therapy with a coherent, conceptually economic model that translates into a workable practice for the therapist (Edwards & Arntz, 2012, p. 20). This approach encourages a schema-based case conceptualization tied closely to treatment planning.

Reflect: Why are you reading this book? Have you used ST with individuals and now want to try it with couples? Are you new to ST and hope to find an effective therapy for working with traits of personality disorder?

1.9 Brief Outline of the Stages of Schema Therapy for Couples

The following is a suggested outline of treatment (unfamiliar terms and techniques are explained later in the book):

1. *Empathic engagement.* Make an emotional connection with the couple. The challenge in the first session is to see issues “through the eyes of both.” Allow the couple to demonstrate their dysfunctional way of relating.
2. *Initial contract for alliance and therapy.* This can include the two commitments of working on the relationship and not deliberately behaving badly towards the partner (Hargrave, 2000).
3. *Assessment.* Possibly use a genogram. Use ST questionnaires and other resources. Focus on understanding the childhood origin of adult relationship problems. What issues belong where? Be guided by Young’s five tasks. Try to conceptualize the information in a “mode map” for both partners as a reference point for your further work.
4. *Formulation.* Clarify an ST-C understanding of problems in terms of Young’s schema chemistry, clashes, and locking. What are the dynamics of attraction? Put gridlocked problems and patterns into schema and mode conceptualizations. Use mode cycle clash-cards to identify how dysfunctional modes play out. Develop a comprehensive but focused treatment plan.
5. *Treatment interventions.* Base interventions primarily on mode maps, eventually including the most prominent schemas, to deal with the legacy from the family of origin. De-escalate mode clashes. Use ST interventions, including imagery, limited re-parenting, chair-work, strategies to strengthen Healthy Adult mode, and behavior pattern breaking. Find a balance of individual and couple sessions. Move from

dysfunctional modes to healthier coping modes. This includes coaching the couple to identify and de-escalate schema activations and mode clashes (using mode cycle clash-cards, mode dialogs, empathic confrontation, and empathic compassion). If possible, encourage couple interactions that enable a re-parenting of each other and dealing with bad memories. The couple learns to apply dialog tools and special techniques to enhance re-parenting.

6. *Building friendship.* Conduct connection exercises to build friendship (Gottman & Silver, 1999) and provide building blocks for more secure attachment (similar to emotion-focused therapy for couples) to increase positive behaviors. Encourage the couple to take responsibility for their own relationship. Strengthen Healthy Adult and Happy Child modes. Use new clashes for the couple to practice skills and to coach them in the use of those skills. Use the concept of bringing in the “A team” to resolve conflict.
7. *Termination and relapse prevention.* Work towards a successful end of therapy with periodic “relapse prevention” sessions. Help the couple to articulate a relationship story, incorporate the experience of therapy, learn how to anticipate future mode clashes, and create a plan for dealing with crises. Arrange periodic check-ups and readjustments. Perhaps the couple can make an agreement about being willing to return to therapy for a minimum of one session if problems reoccur.

Reflect: As you look over this outline of ST-C, what aspects do you think would be easy for you to put into practice? What would be very challenging? Think about making small steps to build up your skills and to gain confidence before attempting more advanced skills.

Summary

In this chapter we have introduced some of the defining characteristics of ST, including how it developed first with schemas and then with modes. The focus has always been on treating difficult people, and there is growing evidence of therapeutic effectiveness with individuals, especially in group treatment programs. ST-C is designed to use similar interventions in treating couples. This chapter has also outlined the stages of treatment with couples.