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Schema Therapy in Historical Perspective

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Schema Therapy (ST) evolved as a treatment for complex psychological problems over a period of some 20 years. In due course, it became sufficiently defined and operationalized that it could be manualized and evaluated in a randomized controlled trial (RCT) (Giesen-Bloo *et al.*, 2006). As suggested by Young (2010), its recent development can be divided into three phases. The first was a period in which Young's reflection on his own cases led to the formulation of the key concepts. He then put these to work and tested them in new cases, not only on his own, but increasingly in consultation with clinicians working closely with him. In the second phase, a group of Dutch researchers conducted the RCT and in the process large numbers of Dutch psychologists contributed to the ongoing theoretical and clinical development of the model. In the third, Farrell and Shaw published a study of a group therapy model that added yet another dimension to ST treatment.

ST is an integrative therapy that draws on many concepts and methods that had existed before it evolved with its own identity. In this chapter we will look back at developments in cognitive behavior therapy and other psychotherapies, particularly between 1960 and about 1995, that have directly influenced the theories and techniques of ST. We will also look farther back within the history of psychotherapy and point to parallels that may or may not have had a direct or traceable influence. Readers will see how ST as developed by Young is part of a broader trend in cognitive therapy of attending to information processing that is not readily accessible to conscious awareness. It will become clear how it draws on schema models and theories and incorporates methods and techniques developed within other psychotherapy traditions. Next, we will examine each of the three phases. Lastly, we will reflect on the relationship between ST and science.

Beyond Beck's Cognitive Therapy

The movement towards integration in psychotherapy

In the 1970s and 1980s, at most universities in the US psychology departments involved in training clinicians were associated with one of two paradigms: the older psychoanalytic and psychodynamic tradition and the emerging cognitive behavior therapy (CBT). Those associated with CBT argued that theirs was the only approach founded in experimental science and began to underline the credibility of their approach by demonstrating the efficacy of CBT treatments in RCTs. They were often dismissive not only of psychodynamic approaches but also of the humanistic and experiential therapies that had only a limited influence in most universities but were a growing force outside. However, once qualified, many practitioners found the academic models too limited to address the range of clients and client problems they were presented with in practice and a chronic rift developed between university-based researchers and clinicians (Dattilio, Edwards and Fishman, 2010). In due course, some university-based clinicians and researchers experimented with the humanistic and experiential approaches. As those trained in CBT explored psychodynamic approaches more carefully (and vice versa), they began to integrate them into more comprehensive treatment models. This was reflected in the founding of the *Journal of Psychotherapy Integration* in 1990 and the publication of the *Handbook of Psychotherapy Integration* (Norcross and Goldfried, 1992). The development of ST was part of this wider process.

ST is a theoretical and technical integration that is largely the work of Jeffrey Young. He developed the approach on the basis of his own clinical observations, his reflection on cases he found difficult and challenging, and in collaboration with colleagues who worked with him using the model on their own cases as it evolved. Many of these original collaborators are acknowledged by Young, Klosko, and Weishaar (2003, p. ix). As a graduate trained in clinical psychology in the US during the 1970s, Young would have had a broad theoretical grounding. After qualifying, he did postdoctoral training in Beck's cognitive therapy (CT) in Philadelphia and subsequently was clinical director of the Center for Cognitive Therapy in the early 1980s. At that time the basic treatment model for depression had already been developed (Beck *et al.*, 1979) and work was underway to adapt the model for anxiety disorders as well as to test the models in clinical trials. Like many clinicians trained in treatment models designed for fewer than 20 sessions, Young found himself preoccupied with those clients who did not respond to short-term approaches. He set about identifying the characteristics of these clients and finding treatment strategies that would address the difficulties they presented. In 1984, the first author was given a seminar handout by Young entitled "Cognitive therapy for personality disorders and difficult patients," which summarized his analysis of the problems posed by these clients. This would later be incorporated into Young's (1990) first publication on ST and into Young *et al.*'s (2003) ST manual. In the process of finding ways to address the needs of these clients, Young added to the already rich array of cognitive and behavioral techniques in which he had been trained by incorporating relational perspectives, experiential techniques, and the recognition that the self is not a unity, but functionally divided into parts that can be in conflict with each other.

Beck's cognitive therapy

Beck's CT is often thought of as a brief, manualized, and highly technical approach designed for short-term interventions, like other therapies within the broad family of CBT. This is at least in part because of the constraints of outcome research that require psychotherapies to be packaged in this way. However, CT as developed by Beck and colleagues from the 1970s was never just a set of CBT techniques. Beck had been trained in psychoanalysis. Although he quickly became disillusioned with working with clients who were free-associating on a couch and began to experiment with a more pragmatic and practical approach, he did not entirely jettison his former training. By the time Young was training with Beck, CT was already an integrative therapy. This is acknowledged in the introduction to the landmark book on CT for depression (Beck, Rush, Shaw and Emery, 1979) which listed a diverse range of forerunners whose influence had been incorporated into the new approach (see also Mahoney and Freeman, 1985).

This included cognitive approaches such as George Kelly's (1905–67) Personal Construct Theory and the work of Albert Ellis (1913–2007), whose main focus was the development of a cognitive therapy based on the classic Stoic maxim that it is not events that distress us but the meaning we give to them. Identifying distorted or exaggerated personal meanings and actively challenging them was central to Ellis's therapy – which changed its name over the years from Rational Therapy to Rational Emotive Therapy to Rational Emotive Behavior Therapy as Ellis integrated new aspects. Behavior therapy was another important component. Joseph Wolpe (1915–97), who had developed systematic desensitization (Wolpe, Salter and Reyna, 1964), was a professor at the same university as Beck and CT was being put together at a time when many behavior therapists were taking a pragmatic approach to behavior change (London, 1972) and linking cognitive and behavioral methods into what would soon be called cognitive behavior therapy (CBT). Another important influence came from Carl Rogers' (1902–87) client-centered therapy and from phenomenological and existential writers who emphasized understanding the lived experience of clients and the idiosyncratic nature of each individual's patterns of thought and feeling.

Beck's approach to intervention was very different from traditional psychodynamic practice. However, concepts from several psychodynamic theories were used as a basis for case formulation and treatment planning, provided they were grounded in evidence from the data of the case. Humorously, in 2000, during a dialogue with Albert Ellis, Beck acknowledged this when he referred to himself as “a closet psychoanalyst” (Beck and Ellis, 2000). Alfred Adler (1870–1937) was one of these influences. His break with Sigmund Freud (1856–1939) had come about because of his own cognitive emphasis and an approach to therapy that had many parallels with the pragmatic, action-oriented methods that would come to be called CBT. Another was Karen Horney (1885–1952). Her model included an understanding of the way early experiences could lead to negative experiences of self and the world, and compensatory processes that might get set up to neutralize these. This became an important feature of case conceptualization in cognitive therapy and later, ST. Beck would regularly appeal to Horney's phrase, “the tyranny of the shoulds” (which Ellis, in his robust manner, had rebranded “musterbation”), a precursor to ST's “demanding parent.”

Two other important influences are discussed later in this chapter. Franz Alexander (1891–1964) introduced the concept of the corrective emotional experience and Harry Stack Sullivan (1892–1949) pioneered the understanding of interpersonal schemas and the way they interact in relationships. Beck *et al.* (1979) also acknowledged being influenced by Eric Berne (1910–70), the founder of Transactional Analysis (TA), and Jerome Frank (1909–2005), who had identified common factors contributing to effectiveness in all psychotherapies.

What distinguished the emerging cognitive and behavioral therapies was a focus on and careful analysis of factors currently maintaining clients' problems. These included clients' negative beliefs and assumptions and vicious cycles of thought and behavior, and the way in which these impacted within the contexts of their lives and personal concerns. Despite this emphasis, developmental analysis of factors likely to predispose clients to current difficulties has always been part of case formulation in CBT (e.g., Hawton, Salkovskis, Kirk and Clark, 1989) and case conceptualization in CT always took into account the client's history. Emery, who worked closely with Beck (Beck and Emery, 1984; Beck *et al.*, 1979), pointed out that clients would be more motivated to change beliefs and behaviors if they recognized how they had developed:

Discover where your beliefs come from . . . by going back and seeing where you adopted your beliefs you can often make them clearer to you . . . Many beliefs are passed down for generations. We traced one patient's fear of going broke back three generations to immigrants from Russia who were very poor. (Emery, 1982, pp. 186–7)

Nevertheless, pressure to manualize the therapy for treatment trials meant that there was more emphasis on immediate maintaining factors than developmental analysis of clients' problems.

The Integration of Attachment, Interpersonal, and Object Relations Theories

The limits of the collaborative relationship

An important aspect of the collaborative relationship in CT is the therapist's empathic understanding of clients. This is directed more broadly toward appreciating what clients were struggling with in their lives and more specifically toward what they were experiencing moment by moment in the therapy session. This was the hallmark of Rogers' client-centered approach in which the therapist offered the client a relationship characterized by unconditional positive regard, empathy, and congruence (genuineness). It had been Otto Rank (1884–1939) who, in 1935, had introduced Rogers to what at that time seemed a revolutionary approach to the therapeutic relationship. Until then he had worked in a traditional psychoanalytic model (Kramer, 1995).

In addition, however, the collaborative relationship is one in which therapists encourage clients to identify goals for therapy and to work on them together. Many clients who seek psychological help can respond quickly to this kind of collaborative,

empathic, and action-oriented approach. But this does not work for a significant proportion of clients. Some don't seem to take naturally to collaboration, but act passively and helplessly, expecting the therapist to do all the work. Others become hostile or withdrawn and unmotivated. Yet others work to change their thoughts and experiment with new behaviors but do not experience meaningful change (Young, 1984). Cognitive therapists have to find a balance between being empathic and attending to clients' experience on the one hand, and working actively for change on the other. For some clients this balance is difficult to maintain. Some feel misunderstood when therapists encourage them to change their thoughts or try out new behaviors. Some simply won't do homework and in other ways appear to be uncooperative. Yet if therapists merely focus on empathically attuning to them, they do not seem to make much progress in actually changing their lives (Edwards, 1990b).

The integration of relational perspectives

These aspects of the therapeutic process had been the focus of relational theories for several decades. Sullivan's (1950, 1953) interpersonal theory, object relations theories (Cashdan, 1988), and Bowlby's (1979) attachment theory all proposed that each individual's engagement in human relationships was governed by cognitive representations of self and other, and the nature of the relationship between them. Trained as a psychoanalyst, John Bowlby (1907–90) was influenced by ethological research based on close observations of animals and their relationships to their young. In his theory, which was psychodynamic and developmental, but conceptualized in cognitive terms, he drew on metaphors from information processing and described how individuals develop "one or more working models, representing principal features of the world" (1979, p. 117). These underlying cognitive structures formed by early experiences encode representations of self and other and shape experience and emotions in later life. This was a cognitive theory with strong similarities to Beck's theoretical model where such internal representations were conceptualized in terms of schemas. By the mid-1980s and early 1990s the relationship between disturbed attachment and personality disorders was an increasing focus of clinical theory and research (Brennan and Shaver, 1998; Perris, 1999; Liotti *et al.*, 2000) and became a central feature of case formulation in ST.

All these theorists recognized the significance of interpersonal or relationship schemas that encoded representations of self and other in relationship and guided interpersonal behavior. They understood that relationship schemas would develop in a healthy and adaptive manner provided certain conditions were met in the social environment, particularly with respect to the quality of relationship offered by those who were primary caretakers. However, they would become disturbed or dysfunctional if the relationship with the mother or other primary caretaker(s) was characterized by emotional coldness, unpredictability, or hostility and abuse. In such cases, individuals would develop problems with affect regulation, becoming either overly restricted in their experience or expression of emotions, failing to develop adequate self-control, or swinging between over-control and lack of control. Their interpersonal schemas would become the source of severe difficulties in interpersonal relationships, especially intimate ones, and would not only lead to difficulties in their lives, but would also impact on the relationship with the therapist from whom they sought

help. As a result, such clients would fail to respond constructively to the therapist's offer of empathic collaboration. Their interpersonal schemas would generate beliefs and assumptions about their therapists – not all of which were easily accessible to awareness – that reflected their earlier experience with neglectful, unpredictable, or abusive caretakers. These would lead to disruption of the collaboration, leaving therapists bewildered and frustrated that the well-meaning help they were offering was not being received in the spirit in which it was intended.

In the early 1980s, cognitive therapists were recognizing these problems and drawing on interpersonal and relational theories to address them (Arnkoff, 1981). Safran's (1984) work on integrating Sullivan's interpersonal theory with cognitive therapy was already underway. His 1984 article was a precursor to what would become a research project spanning over two decades (Safran, Muran, Samstag and Winston, 2005). However, the most important influence on Young was the work of the Italians Guidano and Liotti (1983), who integrated the developmental concepts of Jean Piaget (1896–1980) with Beck's cognitive therapy and Bowlby's attachment theory and spelled out the implications of this approach for working with patients with such problems as depression, eating disorders, and agoraphobia.

Limited reparenting

Attachment theory was an effective tool for formulating the difficulties of many clients who could not form a collaborative relationship. In mode terms, these are clients who have limited development of the Healthy Adult (HA) and whose interpersonal schemas became stuck in dysfunctional childhood patterns. Young (1990) reasoned that technically the theory meant 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 had clients had a better experience with their own parents. This would involve “find[ing] out what needs of the child did not get met and try[ing] to meet them to a reasonable degree” (p. 39).

The importance of therapists offering a parenting relationship had been recognized within psychoanalysis by Ferenczi (1873–1933). He stressed the importance of accessing these child states, engaging in dialogue with them – he called it an “infantile conversation” – and responding in a manner that provided what the client needed and did not receive as a child – what he called “the advantages of a normal nursery” (Ferenczi, 1929). Ferenczi's view was developed by Alexander between 1946 and 1956, who advocated that therapists should behave toward clients not just neutrally, but in a way that provided them with a completely different experience from that which they had had with critical and punitive parents. They should

assume intentionally a kind of attitude that is conducive to provoking the kind of emotional experience in the patient which is suited to undo the pathogenic effect of the original parental attitude. (Alexander, 1956, cited by Wallerstein, 1995, p. 53)

This would provide clients with a “corrective emotional experience” that would change their underlying relational schemas. Within psychoanalysis, this view was

roundly rejected in favor of the traditional neutrality of the therapist. However, as the object relations therapies grew in influence, for example through the work of Michael Balint (1896–1970) and Donald Winnicott (1896–1971), there was increasing emphasis on clients changing as a result of experiencing security and care within the evolving relationship with the therapist (Wallerstein, 1995).

The most explicit experimentation with Ferenczi's principle occurred during the 1970s among TA therapists where the term "reparenting" began to be explicitly used. Initially, this referred to a very radical application of the principle of corrective emotional experience when Schiff (1970, 1977) and colleagues experimented with providing disturbed clients with 24-hour care in a simulated family situation. They allowed them to regress to infantile and childhood states and would meet their needs even to the extent of putting them in nappies and changing them. Although a number of remarkable case studies provided evidence for the therapeutic impact of this approach, the high degree of commitment and organization required to deliver such an intervention meant that it was impractical in most settings. Furthermore, the intensity of interaction and physical contact between therapists and clients made it very controversial.

Nevertheless, a more limited approach to reparenting was adopted by several TA therapists who emphasized the importance of providing a corrective experience. Woollams (1977, p. 365), for example, used it in describing a group therapy approach that integrated TA and gestalt methods. He recommends that therapists should respond to "the cathected little person in a way that is appropriate to her age." The term "cathected little person" is equivalent to activating the Vulnerable Child (VC) mode in ST. So the term "reparenting" came to encompass both therapists' caring attitude toward their clients and their dealing with whatever came up in the relationship in the same way as a good parent would. It was also used to refer to psychodramatic enactments of parenting by the therapist toward the client's VC in imagery and dialogue work. Thus Wallas (1991), working with clients from families with an alcoholic parent, used the term reparenting to refer to a method of presenting healing narratives under hypnosis. In TA, the term "self-reparenting" was also used for the process by which individuals who had been poorly parented learned to become healthy parents themselves (James, 1977). Within ST this would be part of building the Healthy Adult, and would not be conceptualized as reparenting since it did not include the activation and rebuilding of childhood schemas. The history of psychotherapy has provided growing evidence that many clients can reconstruct their basic relationship schemas while carrying on with their lives. Seeing a therapist once or twice a week can be enough to establish a relationship that can provide the kind of corrective experience envisaged by Ferenczi and Alexander, and this can be supported by explicit reparenting in imagery and chair work. So, large numbers of clients can benefit from limited reparenting and it has become an important component of ST.

Empathic confrontation

Beck's concept of the collaborative relationship assumed that therapist and client worked together as a rational team. The therapist's main tool for confronting irrational thoughts or dysfunctional behaviors was through gently evoking cognitive dissonance through Socratic questioning or drawing clients' attention to the self-defeating nature

of some of their behaviors. However Young (1990, p. 41) realized that there are many clients who do not respond to such a rational or gentle approach, and “a more confrontational style” was needed if the processes maintaining the schema were to be changed. The challenge for the therapist is to confront while conveying empathy for the pain clients feel, and their fears of letting go of avoidances and compensations. This means that “the therapist is continually working to find a balance” in providing “empathic confrontation” (Young *et al.*, 2003, p. 93).

This dilemma has been recognized within many approaches to psychotherapy. Within the Rogerian tradition, confrontation is an essential therapist skill:

Failure to confront, when confrontation is needed, permits the continuation of self-defeating or unreasonable behavior and inadvertently implies support for such behavior. (Tamminen and Smaby, 1981, p. 42)

Leaman (1978, p. 631) emphasized the importance of “empathy in confrontation” since “confrontation is an act of caring.” He gave examples of non-empathic and empathic confrontation. Adler and Myerson (1973) collected similar discussions within the psychodynamic tradition, including one in which Welpton (1973) contrasted “empathic confrontation” (p. 266) with “angry confrontation” (p. 263). Cashdan (1988) devotes a chapter to managing confrontation therapeutically in object relations therapy. Within TA, Weiss and Weiss (1977, p. 128) observe that when clients

identify what they need and ask us directly to meet that need, we will usually agree to do so, or at least problem-solve with them about how to get that need met . . . At the same time we will confront substitute behaviors and do our best to minimize their getting any rewards from them.

Thus these principles have been widely recognized for a long time. However, the term “empathic confrontation” has achieved new prominence since it featured as part of ST and appears in more recent literature on working with child abuse survivors (Chu, 1992) and dissociative personality (Schwartz, 1994).

The Integration of Experiential Techniques

Two levels of encoding meaning

Within ST, one of the major innovations compared to CBT was the central place given to experiential techniques. These addressed one of the problems that Young had identified as interfering with response to cognitive therapy in clients who, in spite of working with rational analysis, changing negative thoughts, and even experimenting with new behaviors, failed to achieve change at the emotional level. Models of cognitive encoding recognized that there is not just one system of meaning. Zajonc (1980, 1984) reviewed experimental studies that showed the disjunction between conscious experience and rationality on the one hand, and people’s pre-reflective experience on the other. Greenberg and Safran (1984) provided evidence that rational, language-based cognitive systems were independent of systems associated

with emotion. This became part of Teasdale's (1993) Interacting Cognitive Subsystems (ICS) model that distinguished between *propositional* encoding of meaning, which was language based, and *implicational* encoding of meaning, which was not. There was evidence that only implicational schemas were connected directly to emotional systems, which meant that they needed to be activated and changed if significant change in distressing emotions associated with these schemas was to be achieved.

Within CT, Beck (1985) also pointed out that schemas based on early childhood experiences were not easily accessible to verbal introspection and could be changed only if they were activated. Behavioral exposure was one way to do this – for example, having agoraphobics go out to avoided places and then helping them re-evaluate the cognitions associated with the intense emotions evoked (Coleman, 1981). Imagery provided another route. In an early paper, Beck (1970) recognized that images and fantasies could give access to this level of meaning. He described how repeated rehearsal of a distressing fantasy could result in the fantasy changing to become less distorted and more realistic. Freeman (1981) had also written about how dreams and images could provide access to these levels of cognition. However, the potential of imagery and psychodrama to connect directly with the emotional level had barely been explored, although Arnkoff (1981) described experiments in this direction and Beck and Emery (1985) included some methods, including use of metaphoric imagery and imagery replacement methods, in their account of cognitive therapy for anxiety disorders. By contrast, in several other approaches to psychotherapy, there was already a rich literature on imagery techniques in behavior therapy, hypnotherapy, Jungian therapy, and some psychodynamic approaches (Singer, 1974; Samuels and Samuels, 1975; Singer and Pope, 1978; Shorr, 1983; Sheikh, 1984).

The influence of Gestalt Therapy

In 1984, Young consulted a gestalt therapist who used mainly imagery techniques. Their personal impact on him was immediate. As he later commented, “in about ten sessions of Gestalt Therapy, I learned more about myself than I had learned in a year with the cognitive therapist” (Roediger and Young, 2009). He immediately saw how these experiential methods were a missing piece that could address many of the problems of patients who did not respond to standard CT interventions and began experimenting with using them with his own clients. Others were also experimenting with these methods at Beck's Center for Cognitive Therapy in the mid-1980s. Edwards (2007) had been exposed to them in the United Kingdom and described some of his work with guided imagery during a postdoctoral fellowship, in two widely influential publications that included clinical descriptions and a rationale for the incorporation of these methods into CT (Edwards, 1989, 1990a). Smucker, who was there at the same time, receiving supervision from Young, also had a formative experience with a gestalt therapist and this led to his development of imagery rescripting for PTSD (described by Smucker, Dancu, Foa and Niederee, 1995). Layden also integrated imagery rescripting into a CT approach to the treatment of borderline personality disorder (BPD) (Layden, Newman, Freeman and Morse, 1993). Outside the immediate circle of Beck CT therapists, Lazarus described how gestalt methods such as the empty chair technique could be integrated in multimodal therapy (Lazarus,

1985) and Greenberg and Safran (1987) were providing in-depth accounts of the processes of emotional change set in motion by imagery/dialogue methods. A decade later, Arntz and Weertman (1999) described how to use imagery rescripting and psychodrama techniques in the treatment of current problems that had their roots in personality characteristics related to emotionally charged childhood memories.

An historical perspective on experiential techniques

However, these experiential techniques have a much longer history (Edwards, 2011). Already in the 19th century, Pierre Janet (1859–1947) treated patients with “imagery replacement.” He cured his client Marie of psychogenic blindness that had begun when she shared a bed with a child whose face was disfigured by impetigo by having her relive the events but imagining that the child’s face was normal and that she was friendly and that she stroked her hair and face (Edwards, 2007). For a long time, Janet’s work was sidelined by the dominance of Freud, but in the last few years has been reexamined and re-appreciated (van der Hart, Brown and van der Kolk, 1989; van der Hart and Horst, 1989; van der Hart and Friedman, 1989; Oulahabib, 2009). Carl Jung (1875–1961) developed the method of active imagination in which clients would connect with a feeling and allow images to emerge (Jung, 1960). In contrast to ST’s focus on memories of real events, these tended to be symbolic and could give rise to dramatic journeys or dialogues with mythic figures (Hannah, 1981). However, imagery work of the kind pioneered by Janet continued to be used by hypnotherapists throughout the twentieth century (Edwards, 2011).

Fritz Perls’ (1893–1970) Gestalt Therapy has been particularly influential in its impact on contemporary psychotherapy. Born in Vienna, Perls gradually moved away from the Freudian psychoanalysis in which he had been trained. In this process he was influenced by Wilhelm Reich (1897–1957), who observed the rigidity in posture and the muscles of the body, which he called “character armor.” Reich believed that this was there to prevent the expression of emotions and led to chronic blocking of the flow of energy in the body. His aim was to get the energy flowing freely and he used muscle relaxation, deep breathing, and other body-focused methods to induce emotional release. Alexander Lowen (1910–2008), who developed Reich’s approach, called it *bioenergetics* (Lowen, 1976). Although this often triggered childhood and infantile memories, Reich himself did not pay much attention to working with the memories themselves. Another important influence on Perls was a lifelong interest in the theater (Madewell and Shaughnessy, 2009). He was actively involved with Max Reinhart’s active drama methods. He must also have known Jacob Moreno (1889–1974), based in Berlin, who experimented with drama methods from as early as 1911 and went on to develop psychodrama and apply it in clinical settings (Moreno, 1939). The use of the term “script” in psychotherapy comes from these connections with the theater and Moreno is reported to have said, “Throw away your old script and write a new one” (Jacobs, 1977), a theme that Berne would develop further.

Perls was also strongly influenced by Ferenczi’s work with the traumatized but split-off “inner child” of adult patients. Ferenczi had recognized that it was important to heal this and, as a therapist, took a role that we now recognize as reparenting

(Edwards, 2007). Perls developed a therapy with a strong emphasis on feelings, needs, and impulses. Imagery and empty-chair dialogues were central techniques in bringing these to awareness, allowing them full expression, and promoting resolution. Transcripts of Perls' demonstrations of these methods in workshops, mostly published posthumously, were particularly influential (Perls, 1973). Many TA therapists also integrated these imagery and psychodrama methods with their concepts of ego states and scripts, often in a group therapy environment. The concept of scripts was central to TA and treatment focused on analyzing them as a means of understanding the rigid, repetitive, and compulsive patterns that perpetuated unhappiness (Steiner, 1974). As Berne (1961, p. 118) had put it: "The object of script analysis is to close the show and put a better one on the road." There was an appreciation of the importance of unmet needs and the expression of suppressed emotions. It was also recognized that the experience of the child, often alone, frightened, confused, and angry, needed to be reactivated and rescripted (Goulding and Goulding, 1979; Erskine, 1980; Erskine and Moursund, 1988).

Perls' methods were particularly influential in the human potential movement, where humanistic therapists were focusing on personal growth. They often did this through offering group experiences not only to clients with significant psychological problems, but also to those generally interested in self-exploration and development. However, this kind of format meant that often participants' schemas would be triggered but there was insufficient follow-up to ensure that the next stage of therapy was embarked on. For this reason many clinicians saw these methods as dangerous and did not appreciate their potential within a systematic therapy. Young himself had this experience. As a graduate student he attended several gestalt marathon weekends but found them painful and distressing as there was no follow-up on what had been evoked. However, in 1984, having trained in cognitive therapy, and challenged by his own difficult cases, he saw these experiential methods in a new light as a result of his positive experience of individual Gestalt Therapy. He then recognized how they could be usefully integrated into a systematic and structured therapy.

The evolution of schema mode work

Since ancient times, conflict between incompatible impulses, desires, or beliefs has been recognized as part of human nature. An Egyptian papyrus from 2200 BC describes a disillusioned and suicidal man conversing with his "Ba," a deity who encourages him to find courage and hope despite the selfishness and cruelty that surround him (Lindorff, 2001). During the 19th century such conflicts were explored in depth in fiction (Edwards and Jacobs, 2000) as well as in philosophy, psychiatry, and psychology (once it emerged as a separate discipline). Widespread investigations of hypnotic phenomena and dissociated states at the end of the 19th century provided extensive observations on which new theories were based. In France, as early as 1868, Durand, a hypnotherapist, used the term "polypsychism." Beneath our "ego-in-chief," he argued, is a multiplicity of sub-egos, each of which

had a consciousness of its own, was able to perceive and to keep memories and to elaborate complex psychic operations. The sum total of these subegos constituted our unconscious life. (Ellenberger, 1970, p. 146)

Most theories of psychotherapy address this multiplicity in one way or another. At the turn of the 20th century, Freud used the concept of “splitting” and explored the conflicts between ego, superego, and id. According to Adler, we each have several sets of inconsistent beliefs and attitudes and in order to create an illusion of consistency, at any time one set of beliefs dominates and others are pushed out of awareness (Edwards and Jacobs, 2000). Jung referred to “feeling toned complexes” as well as to “subconscious personalities” and “subpersonalities” (Redfearn, 1994), and work with sub-personalities was an important aspect of psychosynthesis (Assagioli, 1965), developed by the Italian Roberto Assagioli (1888–1974). By the time ST was emerging, the concept of sub-personalities was being widely used in object relations psychology (Redfearn, 1994) and in the humanistic movement (Rowan, 1990).

Several psychotherapy traditions that recognized the importance of healing the inner child have influenced this aspect of ST. These include the work of Ferenczi and the TA/gestalt therapists already mentioned, as well as the work of Alice Miller and Jungian psychotherapy, where there was an emphasis on the inner child as a source of creativity and guidance (Abrams, 1990). Stone and Winkelman (1985) gave detailed descriptions of their voice dialogue method, which includes a great deal of work with the inner child. Bradshaw (1988) drew many of these traditions together in his *Healing the Shame that Binds You*, a book that particularly influenced Young. Several other explorations of the healing impact of working directly with childhood memories and fragmented and dissociated child parts of the self were published in the years that followed. For example, Bradshaw (1990) presented further accounts of his work in the area, Capacchione (1991) explored the use of art materials (drawing and painting), while Ingerman (1991) described and explored the potential of the therapist’s intuition in guiding this kind of work.

What makes this approach so compelling is the way in which identifying parts of the self clarifies the nature of underlying conflicts. 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” (Berne, 1961, p. 4). Indeed, quite independently, Theodor Reik (1888–1969) had observed,

there are three persons in the consultation room. . . . The analyst, the patient as he is now, and the child who continues his existence within the patient. (Reik, 1948, p. 306)

John Watkins, a hypnotherapist, also used the term “ego states,” incorporating it into the name of the therapy that he developed – ego state therapy (Watkins and Johnson, 1982).

Beck addressed this multiplicity by means of a “schema mode model,” which he used during a workshop in Oxford during the 1980s to help a borderline patient understand her different and confusing emotional states. 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 (see Arntz, 2004). As Young observed those that could be seen again and again across cases, he began a systematic identification of schema modes. By the time of the publication of Young *et al.* (2003) a dozen or so important ones were identified and described. As the model was extended to address a wider range of personality disorders, so more modes

were separated out and soon 21 modes would be described by Lobbestael, van Vreeswijk, and Arntz (2007). Humanistic therapists often used colorful terms for these parts of the self. Roth (1989, p. 155), for example, gives a vivid list that includes “Priscilla Perfect . . . Norma Nobody . . . Tommy Tuneout . . . Tara Tuff . . . Captain Control.” Most of these can easily be mapped onto the modes used in ST, and schema therapists are free to use personalized names for modes, often ones suggested by clients themselves.

Three Phases in the Development of Young’s Schema Therapy

As we have seen, integration of concepts and formulations across different traditions of psychotherapy has been ongoing for at least a quarter of a century; the development of ST has been part of this wider process. Young (2010) has suggested that there have been three major phases in the evolution of the ST that we are familiar with today.

Phase I: ST as a strategic, formulation-driven approach to treatment

The first phase of the development of ST was driven by the challenge of the kinds of difficult cases that so easily led to treatment failure with brief or one-dimensional treatment approaches. This led to the development of increasingly refined methods of case formulation and treatment selection that could address a wider and wider range of difficult clinical problems. Although many clinical problems respond to quite brief interventions, difficult cases, particularly those where clients have personality disorders, call for more a strategic approach within which clinicians can draw on a range of technical interventions. What Young (1990) initially called schema-focused therapy developed as an adapted version of CT. The main technical differences were the greater focus on early schemas and the integration of relational and experiential approaches. These provided for greater flexibility on the part of therapists in responding to the needs of clients. As ST evolved, there was an increasing focus on addressing the difficulties presented by particular kinds of challenging cases. Thus publications in the early to mid-1990s addressed “personality disorders” or “characterological problems” (Young, 1990; Young and Lindemann, 1992; Bricker, Young, and Flanagan, 1993). A little later, formulations appeared addressing specific disorders such as narcissistic personality (Young and Flanagan, 1998), substance dependence (Ball and Young, 2000), bipolar disorder (Ball, Mitchell, Mahi, Skillecorn, and Smith, 2003), BPD (Kellogg and Young, 2006), and eating disorders (Waller, Kennerley, and Ohanian, 2007).

By the end of the 1990s Young’s approach had achieved a distinct identity, with a particular model for case formulation and intervention planning. At any phase of the therapy, the choice of interventions is based on an understanding of: 1) the client’s early maladaptive schemas; 2) dysfunctional schema coping methods; 3) the developmental factors that led to their formation; 4) the manner in which they play out in terms of modes; 5) how these patterns affect the client’s current life in work, leisure, and relationships; and 6) the impact they have on the relationship with the therapist. The mode approach provides the ST therapist with a clear guideline with

respect to goals of therapy: to build the HA, to heal the VC, and to reduce the power of self-defeating modes such as the Critical/Punitive Parent, the Overcontroller, and Protector modes. This was now called “schema therapy,” a term first used in Ball and Young’s (2000) article on substance abuse and then for the comprehensive manual which was in preparation and soon to appear (Young *et al.*, 2003).

Phase 2: The impact of the Dutch research

Young’s ideas attracted considerable interest in Europe, where the pre-CBT paradigm that personality has an influence on psychopathology remained stronger than in the US. However, the scientific recognition of Young’s ST lagged behind. It was research on ST in the Netherlands that was to change this. This was initiated by Arnoud Arntz, who had accidentally discovered that some of the patients he treated early in his training and who responded poorly to regular CBT were labeled by others as “borderline” and considered to be untreatable. Resisting this kind of therapeutic nihilism toward BPD, Arntz set out to understand borderline pathology from a ST point of view and integrated new techniques designed to help these patients better incorporate corrective information at the schema level. Reading the work of Edwards (1990a, 1990b) he felt supported in his belief that experiential techniques would be helpful and invited Padesky and Beck to offer workshops in Maastricht. This led to his developing an expanded form of CT for BPD based on the view that these clients should partly be viewed as experiencing the world like little frightened children who felt abandoned in a dangerous world where nobody could be trusted. His approach incorporated childhood trauma processing using experiential techniques like drama therapy and imagery rescripting (Arntz, 1994; Arntz and Weertman, 1999).

Arntz wanted to develop this into a model that could be used in a clinical trial. He approached Beck, who recommended the work of Young, which he regarded as the most promising CT model for this disorder. This resulted in a fruitful collaboration between Arntz and Young, as both soon realized how well their ideas and models matched. The next step was the planning of a RCT conducted in the Netherlands over three years. The results were published in the leading journal in the field, the *Archives of General Psychiatry* (Giesen-Bloo *et al.*, 2006). The finding that ST was superior to a specialized highly regarded psychodynamic treatment for BPD and the recognition of the methodological quality of the trial led to an enormous increase in interest in both the clinical and scientific community. Suddenly, the position of ST had changed: it was now an evidence-based treatment. A by-product of the trial was that many of the therapists started to train new therapists in ST, initially in the Netherlands, but soon elsewhere in Europe, notably in Germany and the UK, speeding up dissemination. The term ST soon became institutionalized in the organization founded to provide networking, training, and certification of this therapy model: the International Society of Schema Therapy (ISST). Despite this, the term “schema-focused therapy” continued to be used in influential research studies – including the Dutch RCT (Giesen-Bloo *et al.*, 2006; Bernstein, Arntz, and de Vos, 2007; Gude and Hoffart, 2008; Farrell, Shaw, and Webber, 2009) and Waller *et al.* (2007) even used the term “schema focused cognitive-behavior therapy.”

The influence of the Dutch research was not restricted to this RCT. Other studies were published, notably on the schema mode model and on imagery rescripting (e.g.,

Weertman and Arntz, 2007); and applications of ST and the mode model to other personality disorders were developed and rigorous empirical tests set up, e.g., for Cluster C, paranoid, narcissistic, histrionic, and anti-social PDs, including in forensic patients (Bernstein *et al.*, 2007). Another Dutch RCT demonstrated that ST could be successfully disseminated in clinical practice and that telephone availability of therapists outside office hours was not essential for its success (Nadort *et al.*, 2009).

Phase 3: Group schema therapy

Meanwhile, a parallel development was the work of Joan Farrell and Ida Shaw on a group therapy format for ST (see Farrell, Shaw, and Reiss, this volume, Part 4, Chapter 5). Experiential therapy played a significant part in the development of both of them. Farrell, who trained in the US at the same time as Young, had personal therapy with a bioenergetics therapist. Shaw was trained in Canada in developmental psychology and experiential therapy. They recognized the need to adapt traditional psychotherapy to deal with deficits in early emotional learning and failed attachment in BPD patients. Their collaboration led to the development of an integrative model for group therapy of BPD. This incorporated a reparenting focus from the beginning and was described using the phrase “emotional awareness training” in the first issue of *Cognitive and Behavioral Practice* (Farrell and Shaw, 1994). At this time they recognized the similarities between their approach and the schema-focused model described by Young (1990), and when, in 2002, one of Farrell’s supervisees attended a workshop with Young and was exposed to the new mode model, they immediately incorporated it into their group work. By the time they met Young in 2004 they recognized that what they had developed was a group version of ST that integrated interpersonal-process, person-centered, and educational group models, always with the therapists as active directors or “good parents” (Farrell and Shaw, 2010).

Unlike most CBT or dialectical behavior therapy (DBT) models, the Farrell–Shaw model is not individual therapy done while a group watches. Capitalizing on the strengths of group therapy, it adds three valuable features to the individual ST approach. First, the therapeutic factors of group psychotherapy identified by Yalom (1985) directly impact on the main schemas of BPD patients. These include *universality* (members learn that their problems are shared by others), *cohesiveness* (members experience a sense of belonging and acceptance), and *corrective recapitulation of the primary family experience* which catalyzes the reparenting and experiential learning components of ST. Second, two therapists run the group. One focuses on maintaining emotional connection and attending to the process of the group, and will be alert for identifying and challenging interfering coping modes. This increases access to the HA and VC modes and allows the other therapist to focus on implementing ST interventions to build the HA and address the needs of the VC. Third, having a group of participants allows for several members to contribute when using techniques like imagery rescripting and mode role plays and this enhances mutual support and learning (see Farrell *et al.*, this volume, Part 4, Chapter 5).

The value of this integration of the principles of group therapy with the principles of ST was evidenced in the results of an RCT with BPD patients (Farrell, Shaw, and Webber, 2009). Participants were in regular individual therapy; some received no additional intervention (treatment as usual: TAU) while others attended 30 sessions

of group ST over eight months. There was no change in symptoms in the TAU group, whereas the ST group showed clinically significant change. This means that the group model shows promise for one of the public health challenges of our time – making an evidence-based treatment widely available for BPD. Furthermore, like individual ST, the group model can be adapted for other PDs and Axis I disorders. This third phase is not only an innovation with respect to ST content, but has also become a major impetus for international collaboration in further development and dissemination of ST. There have been promising results from pilot studies of the group model in the Netherlands and of an intensive version for inpatient or day hospital use in the US. A large international RCT is evaluating the efficacy and cost-effectiveness of the model by comparing it to TAU at the participating sites (Joan Farrell, personal communication, November 2010).

Schema Therapy and Its Relationship to Other Schema-based Models

Psychotherapy integration and the focus on schemas

The use of the term “schema” to refer to cognitive mechanisms for abstracting and generalizing from experience has a long history in psychology. The idea that an individual’s underlying schematic model of reality is different from reality itself was set out clearly by Vaihinger in 1911 and drawn on by Adler (1870–1937) in his theories of personality and psychotherapy (Ansbacher and Ansbacher, 1958). It was also central to Bartlett’s (1886–1969) (1932) theory of memory in cognitive psychology, and to Piaget’s (1896–1980) developmental psychology. From the 1970s, the concept of schema became a point of convergence for cognitive and psychodynamic approaches to therapy. For psychodynamic therapists, it had always been their business to identify and change problematic patterns of response developed in infancy and early childhood (Wallerstein, 1995). Discussing this in terms of schemas was put firmly on the map by Horowitz’s (1988) cognitive reformulation of psychodynamic theories. For therapists with a cognitive orientation, it was natural to draw on such a well-established concept in explanatory models and the concept of a schema was central to Beck’s work from the beginning. For many cognitive therapists interested in taking developmental factors into account and addressing longstanding patterns with their roots in the early years, Young’s (1990) schema-focused approach provided a persuasive set of concepts that became increasingly influential.

However, as previously discussed, this was taking place against the background of widespread moves toward integration across approaches to psychotherapy. Today there is a proliferation of integrative psychotherapies, within which cognitive, behavioral, relational, and experiential techniques are used, including, for example, Cognitive Analytic Therapy (Ryle, 1997; Ryle and Kerr, 2002) and Compassion-Focused Therapy (Gilbert, 2005). Within the broad family of CBT, there is widespread recognition of the significance of paying attention to the therapeutic relationship (Leahy and Gilbert, 2007). Within CT, Beck and colleagues’ (1990) *Cognitive Therapy of Personality Disorders* showed how a focus on underlying schemas is an important feature of the treatment of personality disorders. There is also an increasing integration

of methods and techniques from other traditions within the overall cognitive framework. Further development of this trend is evident in the second edition (Beck *et al.*, 1990, 2004).

Meanwhile, the literature on experiential techniques has expanded, led by Greenberg's (2004) research on Emotion-Focused Therapy, which has now spanned a quarter of a century. Subsequently, an emotion-focused treatment for complex trauma was developed (Paivio and Pascual-Leone, 2010), which has many parallels with ST. Increasingly, imagery restructuring and rescripting methods have been applied to the treatment of PTSD (Grey, Young and Holmes, 2002; Ehlers, Hackmann, and Michael, 2004) and imagery rescripting of distressing childhood memories is being incorporated into CBT treatments for a wide range of Axis I disorders, including social phobia, depression, eating disorders, and obsessive compulsive disorder (OCD) (Edwards, 2007). These developments are reflected in a comprehensive practical manual of imagery methods used in CT (Hackmann, Bennett-Levy, and Holmes, 2011).

Within psychotherapy there has been a long history of using experiential techniques, including rescripting of childhood memories, to address persistent psychological problems (Edwards, 2011). However, it is only recently that these methods have received recognition in the scientific world. Three factors have contributed to this. First, the recognition of the limitations of narrow approaches fostered the widespread move toward psychotherapy integration. Second, the broadening of theory within cognitive science made it possible to better understand these methods and make them the subject of research (Teasdale, 1993; Holmes and Mathews, 2010). Third, a range of scientific studies has supported the effectiveness of these methods (Giesen-Bloo *et al.*, 2006; Weertman and Arntz, 2007), including collections of articles in two journal special issues: *Memory* (Hackmann and Holmes, 2004) and *Journal of Behavior Therapy and Experimental Psychiatry* (Holmes, Arntz and Smucker, 2007).

Schema Therapy in the age of integration

So is ST just another integrative system or does it have particular strengths and features that make it distinctive? The answers to these questions have already been touched on in this chapter; others will be found in the chapters that follow. Young himself emphasizes the distinctiveness of CT, particularly from its parent, the CT in which he was trained. He told an interviewer:

. . . both are very active therapies, but CT is typically entirely “rational,” and in fact tries to teach patients to suppress or get rid of their negative emotions. When we work with longer term patients in ST, we try to evoke affect in the sessions, and try to understand where it comes from. ST also goes much deeper: what is called a core belief in CT is not nearly as “core” as what we call schemas. Our whole emphasis on childhood needs comes from attachment theory and is very much different from any concept in CT. ST has a developmental model, and CT doesn't, in my view. (Roediger and Young, 2009)

Although this may be a fair critique of some CBT approaches it is not universally accurate. As shown above, for many CT/CBT practitioners a developmental analysis of clients' problems, attention to relational aspects, focus on connecting with emotions, and use of imagery methods to effect schema level change are now routine.

Nevertheless, Young's work has had an unquestionable influence. There are four reasons for this. First, ST is based on far more than technical eclecticism and offers a deep integration of insights from various schools into a system of therapy with a coherent, conceptually economic model that translates into a workable practice at practitioner level. Second, the emphasis on limited reparenting in repairing early deficits in the basic needs of the patient is (though not uncontroversial) a feature that intuitively appeals to many therapists. Third, many practitioners have been personally influenced by Young's clinical acumen and personal dedication to sharing his work as a trainer. Fourth, recent research has provided evidence for the efficacy of ST (Giesen-Bloo *et al.*, 2006; Farrell *et al.*, 2009; Nadort *et al.*, 2009).

In addition, Young's work has been so influential that many practitioners use techniques that are important in ST without calling themselves Schema Therapists, and perhaps not even fully aware of the influence of ST in putting these methods on the map. This means that therapists who apply for accreditation as Schema Therapists will receive a very distinctive training with the model summarized by Young and colleagues (2003) at its core, enriched by the technical experience of the Dutch researchers (Arntz and van Genderen, 2009) and the growing clinical experience within the broader ST community. The model for training is still evolving, and with the founding of the ISST and the active involvement of ST practitioners from several countries, ST training is likely to reflect the experience of an ever-wider circle of contributors.

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