I

CASE CONCEPTUALIZATION

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Basics

Schema therapy, which was developed by Jeffrey Young (1990; Young et al., 2003), stems from cognitive behavioral therapy (**CBT**) and has been attracting increasing attention since it was first proposed. Young created schema therapy predominantly for patients who did not respond well to "classical" CBT treatment. These patients often experience a variety of symptoms and typically display complex interpersonal patterns, which may be either fluctuating or persistent; they usually meet the criteria for one or more personality disorders. Compared to CBT, schema therapy has a more intensive focus on the following three issues:

1   *Problematic emotions*, which are in the foreground, alongside the cognitive and behavioral aspects of the patient's problems and symptoms. Schema therapy makes intensive use of experiential or emotion-focused interventions — ones that have previously been developed and used in gestalt therapy or psychodrama. The main experiential intervention techniques consist of chair dialogues or imagery exercises. This focus on emotions is important, since problematic patterns in patients with personality disorders are usually maintained by problematic emotional experiences. For example, patients with borderline personality disorder (**BPD**) typically experience intense self-hatred; they can hardly distance themselves from this self-hatred on an emotional level, even if they do understand that such hatred is not appropriate. In such cases, the influence of cognitive insight into the connected emotional issues is very low. Such kinds of problem can be treated well by emotional interventions.

2   *Childhood issues*, which are of much greater importance than in standard CBT, enabling schema therapy to integrate approaches or concepts that have so far been mainly considered psychodynamic or psychoanalytic. Biographical information is mainly used to validate patients by enabling them to understand the childhood origin of their problematic behavioral patterns. One goal is to help patients understand their current patterns as a result of dysfunctional conditions during their childhood and youth. However, in contrast to psychoanalysis, "working through" the biography is not considered to be the most important therapeutic agent.

3   The *therapeutic relationship*, which plays a very important role in schema therapy. On the one hand, the therapeutic relationship is conceptualized as "limited reparenting," which means that the therapist takes on the role of a parent and displays warmth and caring behavior towards the patient—within the limits of the therapeutic relationship, of course. It is important to note that the style of this reparenting relationship should be adapted to the patient's individual problems or schemas. Particularly for patients with personality disorders, the therapeutic relationship is regarded as the place in which the patient is allowed to and dares to open up and show painful feelings, try out new social behaviors, and change interpersonal patterns for the first time. Thus the therapeutic relationship is explicitly regarded as a place for patients to work on their problems.

Schema therapy offers both a complex and a very structured approach to conceptualizing and treating a variety of problem constellations. Thus schema therapy has been developed not for specific disorders, but rather as a general transdiagnostic psychotherapeutic approach. However, during its ongoing development, specific models for treatment of various personality disorders have emerged and been developed within schema therapy, which are introduced later in this book (Section 2.3). In this chapter, we will first give an overview of the original schema concepts, describing each maladaptive schema briefly and illustrating it with a case example. We will then introduce the development of the schema mode concept and the character of schema modes and their assessment. Finally, we will describe schema-therapy interventions based on the schema mode approach. Simply put, most interventions can be used during treatment both with the original schema and with the schema mode approach. Take for example a "chair dialogue" with two different chairs, where the patient's perfectionist side holds a discussion with the healthier and more relaxed side. This

intervention can be regarded both as a dialogue between the modes of the demanding parent and the healthy adult, and as a dialogue between the schema "unrelenting standards" and the healthy side of the patient. Therefore, the interventions described with the schema mode model could also be used in therapy applying the original schema model.

1.1   Maladaptive Schemas

The so-called early maladaptive schemas (**EMS**s) are broadly defined as pervasive life patterns which influence cognitions, emotions, memories, social perceptions, and interaction and behavior patterns. EMSs are thought to develop during childhood. Depending on the life situation, individual coping mechanisms, and interpersonal patterns of an individual, EMSs may fluctuate throughout the course of life, and often they are maintained by these factors. When an existing schema is activated, intensive negative emotions appear, such as anxiety, sadness, and loneliness. Young et al. (2003) defined 18 schemas, which are ordered into five so-called "schema domains." The definition of these EMSs is mainly derived from clinical observations and considerations, and is not empirically or scientifically developed, although research supports their existence.

Any person can have either a single schema or a combination of several schemas. Generally all human beings do have more or less strong schemas. A schema is considered pathological only when associated with pathological emotional experiences and symptoms, or impairments in social functioning. Patients with severe personality disorders typically score highly on many of the schemas in the Young schema questionnaire (Schmidt et al., 1995). In contrast, therapy clients with only circumscribed life problems who do not fulfill the diagnostic criteria of a personality disorder and who have a higher level of social functioning usually score highly only on one or two of the schemas. Table 1.1 gives an overview of Young's schema domains and schemas.

Case example

Susan is a 40-year-old nurse. She takes part in day treatment, with the diagnosis of chronic depression. Susan reports severe problems at work, mainly bullying by her colleagues, which has resulted in her "depressive breakdown." Susan's most conspicuous feature is her

inconspicuousness. Even 2 weeks after her admission, not every team member knows her name; she does not approach therapists with personal concerns and does not make contact with other patients. In group therapies, she is very quiet. When the group therapist explicitly asks for her contributions, she tends to confirm what everybody else has already said, and generally reacts very submissively and obediently. When faced with a more challenging situation, such as appointments with the social worker to discuss her complicated job situation, she avoids them. However, when confronted with her avoidance, Susan may unexpectedly react in an arrogant manner. After a couple of weeks in treatment, Susan's antidepressive psychotherapy seems to become stale, as she ostensibly avoids active behavior changes.

In the schema questionnaire, Susan has a high score on the "subjugation" schema. She always orients towards the needs of other people. At the same time, she feels powerless, helpless, and suppressed by others. She does not have any idea how to act more autonomously or how to allow herself to recognize her own needs. Diagnostic imagery exercises are applied, starting from her current feeling of helplessness and lack of power. In the imagery exercises, Susan remembers very stressful childhood situations. Her father was an alcoholic who often became unpredictably aggressive and violent. Her mother, on the other hand, was very submissive and avoidant, and suffered from depressive episodes, and thus was unable to protect Susan from her father. Moreover, as the family managed a small hotel, the children were always required to be quiet and inconspicuous.

In the imagery exercise, "Little Susan" sits helpless and submissive on the kitchen floor and does not dare to talk about her needs with her parents—she is too afraid that this will make her mother feel bad and that her father will become aggressive and dangerous. In the following schema therapy, imagery exercises are combined with imagery rescripting. In imagery rescripting exercises, an adult (first the therapist, later Susan herself) enters the childhood scenario to take care of Little Susan and her needs. Concomitantly, it becomes easier to confront Susan empathically with the negative consequences of her overly shy, obedient, and submissive behavior patterns. Disadvantages of this behavior are discussed: she acts against her

own interests, she is not able to care for her own needs, other people become annoyed by her avoidance. Therefore, she must attempt to find the courage to behave more in line with her own interests and needs. With the combination of imagery rescripting and empathic confrontation, Susan becomes increasingly less withdrawn and more engaged and present in the day clinic; she opens up more and starts to articulate her needs. After discussing and analyzing her problematic schema-driven patterns, she reports further problems, which she had hidden at the start of therapy. She starts talking about a sexual relationship with a seasonal worker. She separated from him 2 years ago, as he continuously acted aggressively towards her, but he still gets in contact with her whenever he works in the city. Although she clearly knows that she dislikes this contact, he convinces her time and again to meet and engage in sexual relations, clearly against her needs. After learning about her schemas, Susan herself becomes able to relate this behavior to her overall patterns.

Table 1.1 Early maladaptive schemas (Young et al., 2003) and schema domains

Schema domain	Schemas
Disconnection and rejection	Abandonment/instability
	Mistrust/abuse
	Emotional deprivation
	Defectiveness/shame
	Social isolation/alienation
Impaired autonomy and achievement	Dependency/incompetency
	Vulnerability to harm and illness
	Enmeshment/undeveloped self
	Failure
Impaired limits	Entitlement/grandiosity
	Lack of self-control/self-discipline
Other-directedness	Subjugation
	Self-sacrifice
	Approval-seeking
Hypervigilance and inhibition	Negativity/pessimism
	Emotional inhibition
	Unrelenting standards
	Punitiveness

1.1.1   Schemas in the "disconnection and rejection" domain

This schema domain is characterized by attachment difficulties. All schemas of this domain are in some way associated with a lack of safety and reliability in interpersonal relationships. The quality of the associated feelings and emotions differs depending on the schema—for example, the schema "abandonment/instability" is connected to a feeling of abandonment by significant others, due to previous abandonment in childhood. Individuals with the schema "social isolation/alienation," on the other hand, lack a sense of belonging, as they have experienced exclusion from peer groups in the past. Patients with the schema "mistrust/abuse" mainly feel threatened by others, having been harmed by people during their childhood.

(1) Abandonment/instability   Patients with this schema suffer from the feeling that important relationships which they have formed will never last and thus they are constantly worried about being abandoned by others. They typically report experiences of abandonment during their childhood; often one parent left the family and ceased to care about them, or important people died early. Patients with this schema often start relationships with people who are unreliable, who thus confirm their schema over and over again. But even in stable relationships, which are not threatened by abandonment, the most minor of events (such as the partner's return home from work an hour later than expected) may trigger exaggerated and unnecessary feelings of loss or abandonment.

Case example: abandonment/instability

Cathy, a 25-year-old college student, comes to psychotherapy to get treatment for her panic attacks and strong dissociative symptoms. Both symptoms increase when she has to leave her father after staying over at his house during weekends. She studies in another city, but visits her father nearly every weekend and at holidays. While her relationships with members of her family are very close, her relationships with others are typically rather superficial. She rarely feels truly close to other people, and has never been in a committed romantic relationship. She also reports being unable to

imagine having a truly intimate relationship. When she ponders the reasons behind this, she starts feeling very upset. She breaks into tears, overwhelmed by the feeling that nobody will ever stay with her for long. This feeling is connected to her own biographical history. Her biological mother became severely ill and died when Cathy was 2 years old. Her father married again 2 years later, and the stepmother became a real mother for her. However, her stepmother died rather young herself, very suddenly from a stroke, when Cathy was 16 years of age.

(2) Mistrust/abuse   People with this schema expect to be abused, humiliated, or in other ways badly treated by others. They are constantly suspicious, because they are afraid of being deliberately harmed. When they are treated in a friendly way, they often believe that the other person has a hidden agenda. When they get in touch with the feelings associated with this schema, they usually experience anxiety and threat. In severe cases, patients feel extremely threatened in nearly all social situations. The "mistrust/abuse" schema typically develops because of childhood abuse. This abuse is often sexual; however, physical, emotional, or verbal abuse can also cause severe abuse schemas. In many cases, children were abused by family members, such as a parent or a sibling. However, it is important to keep in mind that cruel acts performed by peers, such as bullying by classmates, can cause extreme abuse schemas as well, often combined with strong failure or shame.

Case example: mistrust/abuse

Helen, a 26-year-old nurse, was sexually and physically abused by her stepfather during her childhood and teens. As an adult she generally mistrusts men and is convinced that it is impossible to find a man who will treat her nicely. She cannot even imagine a man treating a woman nicely. Her intimate relationships are usually short-lived sexual affairs with men whom she meets on the Internet. Sadly, within these affairs she sometimes experiences abuse and violence again.

(3) Emotional deprivation   Patients with this schema typically refer to their childhood as a smooth and OK one, but they commonly did not experience much warmth or loving care, and did not feel truly safe, loved, or comforted. This schema is typically not characterized by feelings of much intensity. Instead, the affected patients don't feel as safe and as loved as they should when others do love them and do want to make them feel safe. Thus, people with this schema often do not suffer strongly from it. Others in the affected persons' environment, however, often sense this schema quite clearly, because they feel that they cannot get close to them or that they cannot reach them with love and support. People with the emotional deprivation schema seem somehow unable to perceive and acknowledge when others like them. This schema often remains quite unproblematic until the life circumstances of the affected person become in some way overwhelming.

Case example: emotional deprivation

Sally, a 30-year-old office clerk, has a high level of functioning: she is good at her job, she is happily married, and she has nice friends and interpersonal relationships. However, none of her relationships give her a real sense of being close to others and being truly loved by them. Although she does know that her husband and her friends care for her a lot, she simply does not feel it. Sally had been functioning very well for most of her life. Only during the last year, when her responsibilities at work and general workload increased considerably, did she begin to feel increasingly exhausted and lonely, and find herself unable to act in order to change her situation. The therapist suggested she should attempt a better work–life balance and try to integrate more relaxing and positive activities into her life. However, Sally does not regard these issues as very important, as she somehow does not feel herself to be significant or worthy enough. She reports that everything "was OK" in her childhood. However, both parents had busy jobs and therefore were often absent. She says that it was often simply too much for her parents to take care of their children after a long day at work.

(4) Defectiveness/shame This schema is characterized by feelings of defectiveness, inferiority, and being unwanted. People with this schema feel undeserving of any love, respect, or attention, as they feel they are not worthy—no matter how they actually behave. This experience is typically connected to intense feelings of shame. This schema is frequently seen in patients with BPD, often combined with mistrust/abuse. People with this schema typically suffered from intense devaluation and humiliation in their childhood.

Case example: defectiveness/shame

Michael, a 23-year-old male nurse, starts psychological treatment for his BPD. He reports severe problems at work due to pervasive feelings of shame. He regards himself as completely unattractive and uninteresting, despite the fact that others often give him compliments and praise him for being a competent and friendly person. When others say such nice things to him, he is simply unable to believe them. He also cannot imagine why his girlfriend is committed to him and wants to stay with him. Growing up, he reports intense physical and verbal abuse by his parents, mainly his father, who was an alcoholic. The father often called both Michael and his sister names and referred to them as "filthy," completely independent of the children's actual behavior.

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(5) Social isolation/alienation People with this schema feel alienated from others and have a feeling of not belonging with anyone. Moreover, they typically feel like they are completely different from everybody else. In social groups they do not feel like they belong, even though others might regard them as quite well integrated. They often report that they were literally isolated in their childhood, for example because they didn't speak the dialect of the region, were not sent to the kindergarten with all the other children, or weren't part of any youth organizations such as sports clubs. Often there seems to be some discrepancy between the child's social and family background and their achievements in later life. A typical example is a person growing up in a poor family with a low level of education, but managing to become the first and only educated family member. These

people feel that they belong nowhere—neither to their family, nor to other educated people due to their different social background. In such cases, this schema can also be combined with defectiveness/shame, particularly when the own social background is perceived as inferior.

Case example: social isolation

David, a 48-year-old technician, completely lacks feelings of belonging. This applies to all kinds of formal or informal groups alike; he actually reports never feeling any sense of belonging in any group throughout his whole life. In his childhood, his family moved to a very little village when he was 9 years old. Since this village was far away from his birthplace, initially he hardly understood the dialect of the other kids. He never managed to become truly close to other children, and since his parents were very occupied by their new jobs and their own personal problems, they hardly offered him any support. Being different from his classmates, he was not integrated into the sports club or the local music groups. He remembers feeling very lonely and excluded when he didn't participate in local activities and festivities.

1.1.2 Schemas in the "impaired autonomy and achievement" domain

In this domain, problems with autonomy and achievement potential are at the fore. People with these schemas perceive themselves as dependent, feel insecure, and suffer from a lack of self-determination. They are afraid that autonomous decisions might damage important relationships and they expect to fail in demanding situations. People with the schema "vulnerability to harm and illness" may even be afraid that challenging and changing their fate through autonomous decisions will lead to harm to themselves and others.

These schemas can be acquired by social learning through models, for example from parent figures who constantly warned against danger or illnesses, or who suffered from an obsessive–compulsive disorder (**OCD**) such as contamination anxiety (schema "vulnerability to harm and

illness"). Similarly, the schema "dependency/incompetency" may develop when parents are not confident that their child has age-appropriate skills to cope with normal developmental challenges. However, schemas of this domain can also develop when a child is confronted with demands which are too high, when they have to become autonomous too early and do not receive enough support to achieve it. Thus patients with childhood neglect, who felt extremely overstressed as children, may develop dependent behavior patterns in order to ensure that somebody will provide them the support they lacked earlier in life, and thus do not learn a healthy autonomy.

(6) Dependency/incompetency Patients with this schema often feel help-less and unable to manage their daily life without the help of others. This schema is typically held by patients with a dependent personality disorder. Some people with this schema report experiences of being confronted with excessive demands in their childhood. These are often (implicit) social demands, such as feelings of responsibility for a sick parent. Since they felt chronically overstressed, they could not develop a sense of competence and healthy coping mechanisms. Other patients with this schema, however, report that their parents actually did not ask enough of them. Instead of helping their children to adequately develop their autonomy during adolescence, they refused to let go and continued to help them with everyday tasks, without giving them any responsibilities.

It may take some time in therapy before this schema becomes apparent, as patients often demonstrate very good cooperation in the therapeutic relationship. After some time, the therapist will feel a lack of adequate progress despite the good cooperation. When a patient starts therapy in an extraordinarily friendly manner and reacts enthusiastically to each of the therapist's suggestions, but a lack of progress is made, the therapist should consider dependent patterns. This might especially be the case when the patient has already been through several therapies with limited success.

Case example: dependency/incompetency

Mary, a 23-year-old student, comes across as very shy and helpless. Her mother still cares for her a lot, particularly by taking over the execution of boring or annoying tasks. She always calls Mary to

remind her of deadlines for her studies. Mary has been used to this overly caring behavior all her life. When she was a child and an adolescent, she did not have any chores to attend to, unlike her classmates. The idea of taking over the full responsibility for her life discourages and scares her. She would actually like to look for a job to earn some money, but feels unable to do so. She reports high levels of insecurity when talking with potential bosses and lacks the confidence in her own skills to start working.

(7) Vulnerability to harm and illness   This schema is characterized by an exaggerated anxiety about tragic events, catastrophes, and illnesses which due to their nature could strike unexpectedly at any time. This schema is seen particularly frequently in hypochondriac or generalized anxiety disorder patients. Patients with this schema often report their mothers' or grandmothers' overcautiousness, frequent worry, warnings against severe illnesses and other of life's dangers, and requests for extreme carefulness and caution during childhood. This cautious guardian may have instructed the child to obey very strict rules regarding hygiene, such as never eating unwashed fruit or always washing their hands after visits to the supermarket in order to avoid sicknesses. This schema can also be found in patients who actually were the victim of severe and uncontrollable events in their lives, such as natural disasters or severe illnesses.

Case example: vulnerability to harm and illness

Connie, a 31-year-old physician, is unsure whether she should try to have children or not. She loves the idea of having two children, but she becomes horrified when she considers just how many traumatic and catastrophic events could happen to a child. Connie knows she might not get pregnant easily in the first place; if she did, the pregnancy could be difficult; the child could suffer from horrible diseases, it could die or suffer horrendous damage in an accident, and so on. However, Connie does not suffer from any heritable disease, and she has no risk factors for a difficult pregnancy, and thus there is no actual reason for her to be worried to such an extent.

The therapist asks her to recall any childhood events related to her pervasive feelings of insecurity and constant worry. Connie spontaneously starts talking about her maternal grandmother. Granny always got very upset when little Connie did things autonomously. The grandmother complained about her inability to fall asleep when Connie was out, even when Connie was 17. She nearly died from anxiety when Connie went to summer camp at 12. Connie's mother was always very close with her grandmother, and mostly shared the grandmother's concerns.

(8) Enmeshment/undeveloped self People suffering from this schema have a weak sense of their own identity. They hardly feel able to make everyday decisions without the need for reassurance from some other—often their mother. Without this special person, they lack the ability to form opinions. This may go as far as an inability to feel like an "individual" altogether. Patients report very close, often also very emotional relationships with the person with whom they are enmeshed. People with enmeshment schema may be very intelligent and well educated, but this does not help or in any way enable them to recognize their own feelings or make their own decisions. Frequently "enmeshed people" do not suffer directly from this schema, because the enmeshed relationship can be experienced as mostly positive. However, secondary problems may arise due to the impairment of autonomy and social functioning, or it could happen that the patient's spouse or partner becomes frustrated with the enmeshment. Often this schema is also related to obsessive–compulsive symptoms.

Case example: enmeshment/undeveloped self

Tina, a 25-year-old secretary, reports occasional aggressive compulsions towards her boyfriend. Their relationship is very close—they spend every waking minute together, either chatting or watching TV—but neither of them has any hobbies or friends of their own. In spite of this close relationship, sexual interaction is rare, mainly due to a lack of interest on her part. During the first psychotherapy sessions, Tina reports intense feelings of insecurity

related to nearly every domain of her life. However, while the therapist sees this insecurity and the lack of hobbies and interests as being part of Tina's problems, Tina herself regards her life as "perfect," except for the compulsions. In particular, she is very enthusiastic about her "wonderful parents." She has a very close relationship with them, too, which she evaluates as 100% positive. She calls her mother several times a day, asking for her advice on virtually any aspect of everyday life, no matter how small, and claims to be happy to discuss any problems with her parents, including her lack of sexual desire.

(9) Failure   This schema is characterized by feelings of being a complete failure and of being less talented and intelligent than everybody else. People with this schema believe they will never be successful in any domain of their life. They tend to have frequently experienced very negative feedback in school or in their families, often including global devaluations of their personae. People engaged in a perfectionist, achievement-oriented activity in their childhood and youth (such as playing classical music, competitive sports, etc.) sometimes develop this schema as well. Demanding and stressful situations, including examinations, are very problematic for such people. This schema sometimes functions like a self-fulfilling prophecy: since people with this schema are so afraid of demanding situations, they may avoid them altogether, resulting in poor preparation and—in a vicious circle—in actual bad results when such situations are unavoidable.

Case example: failure

Toby is a 24-year-old university student who comes to therapy because of depressive symptoms and extreme exam anxiety. With regard to his intelligence and interest in his subject, there is nothing disabling him from being successful, however he often stays in bed all day and postpones doing his homework, and his avoidant behavior patterns are prominent. He is convinced that he will never be able to finish his studies, as he regards himself as a complete failure. This feeling of failure has persisted over the

last few years, although he was able to achieve good marks at school and during the first year of university. Toby talks a lot about his brother, who is 2 years older. The brother is very talented and has always excelled in any activity he participates in. Toby has always experienced feelings of being less smart than and inferior to his brother. Furthermore, Toby was on a swimming team as a child and teen and participated in local competitions. His coach was very ambitious, and whenever Toby came second, the coach displayed his disappointment at Toby's failure to win.

1.1.3   Schema in the "impaired limits" domain

People with schemas of this domain have difficulty accepting normal limits. It is hard for them to remain calm and not cross the line, and they often lack the self-discipline to manage their day-to-day lives, studies, or jobs appropriately. People with the schema "entitlement/grandiosity" mainly feel entitled and tend to self-aggrandize. The schema "lack of self-control/self-discipline" is principally associated with impaired discipline and delay of gratification. Just like those of the domain "impaired autonomy and achievement," these schemas can be learned by direct modeling and social learning. Often patients were spoiled as children, or their parents were themselves spoiled in their childhoods and/or had problems accepting normal limits. However, these schemas can also develop when parents are too strict, when they inflict too much discipline, and when limits are too narrow. In such situations, these schemas develop as a kind of a rebellion against limits and discipline in general.

(10) Entitlement/grandiosity   People with this schema regard themselves as very special. They feel that they don't have to care about usual rules or conventions, and they hate to be limited or restricted. This schema is typically associated with narcissistic personality traits. Patients with this schema strive for power and control, and they interact with others in a very competitive way. They often report that an important figure, such as their father, was a narcissistic role model or a powerful overachiever, thus modeling this schema. It is often the case that controlling and powerful interpersonal behavior was directly reinforced in the patient's childhood. Perhaps the father reinforced the son when the latter controlled his peers, or the parents told their children to feel special because they belonged to a very special family.

Case example: entitlement/grandiosity

Allan is a 48-year-old team leader who first sought psychological consultation due to being bullied in his workplace. With regard to therapy goals, he says: "I have no idea at all how those morons at work can be taught to behave." Towards the therapist he acts in a controlling and bossy manner. According to his self-report, he often devalues his coworkers and behaves insolently at work. When the therapist addresses this behavior, he proudly comments that "It's certainly important to come prepared if you have to deal with me."

(11) Lack of self-control/self-discipline   People suffering from this schema typically have problems with self-control and with the ability to delay gratification. They often give up boring things and don't have enough patience for tasks requiring discipline and perseverance. Others often perceive such patients as lazy, caring only about their own well-being and not working hard enough to fulfill their obligations. The biographic roots of this schema are often similar to "entitlement/grandiosity." However, "lack of self-control/self-discipline" can also be found in individuals who suffered some form of abuse in their childhood. In families that neglect or abuse their children, the kids typically lack the guidance necessary to learn sufficient self-discipline.

Case example: lack of self-control/self-discipline

Steven, a 46-year-old, calls himself a "freelance artist." In reality he relies on social welfare and benefits to make ends meet, but he regularly talks about artistic and musical projects he is currently working on. The only real work he does on his projects is to maintain a very glamorous presence on the Internet. He came to therapy due to depression and a lack of perspective. However, when the therapist tries to identify clear goals with and for him so that he can actually start changing his life for better, he becomes unwilling or unable to make decisions regarding personal goals. Whenever a certain goal becomes more materialized and clearer, he does not want to invest the time and energy to make it a reality.

1.1.4   Schemas in the "other-directedness" domain

People with schemas of this domain typically put the needs, wishes, and desires of others before their own. In consequence, most of their efforts are directed towards meeting the needs of others. However, the ways in which they attempt this differ with the type of schema they possess. Individuals with a strong "subjugation" schema always try to adapt their behavior in a way which best accommodates the ideas and needs of others. In the schema "self-sacrifice," on the other hand, the focus is more on an extreme feeling of responsibility for solving everyone else's problems; people with this schema typically feel that it is their job to make everybody feel good. Those with the schema "approval-seeking" have as a sole purpose pleasing others; thus all their actions and efforts reflect that desire, rather than their own wishes. With regard to the biographical background and development during childhood, these schemas are often secondary. The primary schemas are often those from the domain "disconnection and rejection". I.e., schemas in the domain "other-directedness" may have developed to cope with schemas of disconnection and rejection. Patients may, for example, report that an important parent figure, often the father, was an alcoholic and used to behave aggressively when intoxicated. Thus they felt threatened and developed the schema "mistrust/abuse." To avoid confrontation with the drunken father, they may have learned to behave submissively in such situations. This "secondary" submissive behavior then resulted in a subjugation schema. Often they also had subjugating models, for example when the mother did not stop the father's behavior or did not leave the aggressive father all together, but rather subjugated herself to his aggression.

(12) Subjugation   People with this schema generally allow others to have an upper hand in interpersonal relationships. They mold and adapt their behavior according to the desires and ideas of others, sometimes even when those desires are not explicitly stated but only deduced or guessed. For individuals with this schema, it can be very difficult to get in tune with their own needs, even with the therapist's efforts to help them discover these. During their childhood, patients often experienced dangerous family situations, with one parent subjugating to the other one. Perhaps the mother was very submissive when the father was violent or aggressive, or perhaps any expression of needs and desires was severely punished. Susan (see the start of this section) presents a typical example of this schema.

(13) Self-sacrifice   Patients with this schema constantly focus on fulfilling the needs of others. This schema differs from "subjugation" however insofar as the main goal is not primarily to adapt and succumb to the ideas of others, but rather to discover the needs of others or situational requirements as quickly as possible and attend to those needs. So it is more active and voluntary. Typically such individuals experience feelings of guilt whenever they focus on their own needs. There are high rates of this schema among people working in fields related to providing care and help. In everyday life it can often be observed that time-consuming and effort-requiring jobs or tasks, which are not associated with much financial gain or respect, are often repeatedly performed by the same people. For example, often a person will be a member of the parent–teacher association (**PTA**) first in their child's kindergarten and then later in their primary and secondary schools—even though they may have decided a hundred times not to agree to be elected again. When the PTA holds elections, people with this schema feel so guilty if they do not accept nominations that before they know it they are again reelected. Seen in this light, this schema can frequently be spotted in a number of healthy individuals, often without much clinical repercussion, provided that the person's support system is healthy enough.

Case example: self-sacrifice

Helen is a 35-year-old nurse who has a very good reputation in the clinic she works at, because she is always willing to do extra tasks, and usually does them extremely well. She is a quality-assurance representative at her clinic, she often provides cover for sick colleagues, and she always does a perfect job. Alongside this involvement at work, she is also very involved in her private life as a member of the PTA and similar groups. Helen first seeks psychotherapeutic treatment for a burn-out syndrome. She seems to be extremely overstressed and overwhelmed by her existing high levels of work and personal engagements. However, when the therapist asks her, "Why on earth would you care about *all* these things?" she looks truly surprised and says, "Well, it's not a big deal, is it?"

(14) Approval-seeking People with this schema find it extremely important to make a good impression on others. They spend a lot of time and energy on improving their looks, their social status, their behavior, and so on. The goal, however, is not to become the best (narcissistic self-aggrandizing), but to receive the approval and appreciation of others. Such individuals often find it hard to tune in to their own needs and desires, as the opinions of others and the need for status and approval are always in the foreground.

Case example: approval-seeking

Sarah, a 32-year-old lawyer, seems to be a very satisfied and happy person. She has many friends and interesting hobbies and is married to a very successful man. She comes to therapy because she begins to perceive herself (and her whole life) as "fake." She reports feelings of being an uninteresting and insufficient person. She describes her active and interesting lifestyle as follows: "I always feel under pressure to be part of all the coolest groups and activities and juggle many balls at once, so that I can at least pretend to be interesting and lovable, although I don't feel that way myself at all."

1.1.5 Schemas in the "hypervigilance and inhibition" domain

People with these schemas avoid the experience as well as the expression of spontaneous emotions and needs. People with the schema "emotional inhibition" devalue inner experiences such as emotions, spontaneous fun, and childlike needs as stupid, unnecessary, or immature. The schema "negativity/pessimism" corresponds with a very negative view of the world; people with this schema are always preoccupied with the negative side of things. Those with the schema "unrelenting standards" constantly feel high pressure to achieve; however, they do not feel satisfied even when they achieve a lot, as their standards are extremely high. The "punitiveness" schema incorporates moral codes and attitudes that are very punitive whenever a mistake is made, regardless of whether the mistake was on purpose or accidental.

These schemas may have been acquired by reinforcement and social modeling, for example when parent figures mocked the spontaneous

expression of feelings, thus teaching their children to be ashamed of being emotional. This can also take place indirectly, for example when parents reinforce only achievement and success, and devalue or ignore other important aspects of life such as fun and spontaneity.

Some patients with these schemas report mainly negative experiences regarding intense emotions in their childhood. They started to avoid intense emotional experiences in order to protect themselves against these aversive stimuli. This may relate to the emotions of others rather than their own, for example when members of their family used to argue in a very aggressive and emotional way. Caregivers' moral and achievement standards, and when and how they punished or showed disappointment and anger, contribute to the "unrelenting standards" and "punitiveness" schemas.

(15) Negativity/pessimism   Patients with this schema constantly focus on the negative or problematic side in every situation. They are always anxious that things will not turn out all right, and expect problems everywhere. They often report that this schema has been modeled by parents or other significant figures, who themselves were also extremely pessimistic and always held a very negative view about pretty much everything. This schema can be extremely frustrating for others, because affected individuals slips right back into the negative world view over and over again, no matter how hard others try to help them to see things in a more positive light.

Case example: negativity/pessimism

Eric, a 46-year-old math teacher, has been asked by his wife to see her therapist for couple's therapy. His wife tries to experience more positive activities in her life with the help of her therapist but she keeps mentioning her husband's negative attitude in life, which makes it hard for her to become more positive. Eric confirms that emotionally he is quite a negatively charged person. However, he argues that there are many reasons why it is appropriate to regard the world as a bad place and life itself as a conglomeration of sorrows and problems. He believes that it would be completely unrealistic to have a positive view of life. The therapist asks him about his current job situation. He talks at length about problems with colleagues, bad arrangements within his team, and so on. His

wife interrupts him and points out that he is actually working in the exact field he always intended, and that his career has been very successful so far.

(16) *Emotional inhibition*   Patients with this schema find it unpleasant or ridiculous to show spontaneous feelings. Emotions are regarded as unimportant and unnecessary. Often such individuals recall childhood memories of parent figures mocking them for being enraged or upset. Subsequently the sufferers learned to perceive their emotions as ridiculous and childish, and to devalue them all together. In some cases, people acquired this schema because they felt that the emotions expressed by family members were too difficult to deal with and too intense. Perhaps family members dealt with interfamilial conflicts in an extremely emotional way, or used to complain and talk heatedly about other members of the family with the child. In such cases, the child experienced emotions as threatening and overwhelming. In the treatment of this schema, it is important to establish whether the individual perceives emotions as ridiculous or as threatening.

Case example: emotional inhibition

Peter, a 36-year-old architect, first comes to therapy with a diagnosis of dysthymia. He comes across as an even-tempered man; however, he displays only limited joyful or funny affect. When the therapist tries to joke with him, he hardly even cracks a smile. The therapist senses anger in Peter when he starts talking about his brother, with whom he has a very complicated relationship. However, when the therapist tries to explore these angry feelings more deeply, the patient denies feeling any emotions at all. The therapist inquires about early experiences of emotional expressiveness in his family and Peter reports that his father was emotionally inexpressive and hardly showed any feelings at all. His mother, on the other hand, was an overly emotional person, who often appeared overwhelmed by her feelings. She frequently argued with Peter's brother when both he and Peter were still children. These

arguments made her very upset, to the point that she often cried. Peter's job was to soothe her and calm her down, since she used to come to his room drenched in tears after such conflicts. He experienced these situations as emotionally exhausting and since then he has hated intense emotions.

(17) Unrelenting standards   People with this schema feel permanently under pressure to achieve and to meet their ambitious goals. They usually strive to be the best at everything they do. They find it very difficult to allow themselves to spend time doing fun and spontaneous activities, and almost impossible to value activities which are not related to achievement. Such individuals are typically perfectionist and rigid. They usually do not question their own high standards, but rather view them as natural, even when those standards are quite clearly not achievable or have negative consequences.

Case example: unrelenting standards

Nick is a 44-year-old physician who seeks psychotherapy for the treatment of his depressive symptoms. His depressive episode began after he was appointed as a director of a newly founded department; it was his responsibility to develop the department and his goal to make it successful. In the first sessions, the therapist addresses Nick's own expectations and goals. Nick explains that he has to run all scheduled projects by himself and to do everything perfectly, efficiently, and without major delays. On a rather abstract level, he realizes that his expectations are simply not realistic, because the workload is much too high and he is unable to work more than 16 hours a day. However, on a more concrete level, it is impossible for him to compromise and minimize the overly high and frankly unrealistic standards he has set himself. At the beginning of therapy, he finds it unthinkable to reduce even one of his professional goals or projects in order to make his life more bearable.

(18) Punitiveness   Patients with this schema are convinced that people deserve punishment when they make mistakes. They are usually merciless and very impatient with both themselves and others. They typically report similar models from their childhood.

Case example: punitiveness

Tom, a 52-year-old, is not motivated to start therapy, but his GP urged him to do so after noticing how much he was complaining about his neighbors. Tom is the caretaker of a large house and is always focusing on the mistakes of others. He constantly complains that his neighbors do not comply with the household rules: they make too much noise and so forth. Tom seems to be very engaged in changing the behavior of his neighbors by arguing with them about the smallest of things. Not surprisingly, all of his relationships with the people in his social surroundings are negative. Tom shares with the GP his memory of his parents—they were also very bitter and they did not teach (or even allow) their son to enjoy life. Not unlike Tom, they were very punitive and accused others a lot.

1.2   The Focus on Needs

The focus on human needs is a central idea in schema therapy. Human needs (and the frustrations resulting from their not being met) are seen as the main factor in explaining the genesis of psychological problems. We assume that maladaptive schemas develop when childhood needs are not met adequately. For example, the schemas social isolation/alienation and abandonment/instability develop when the needs for social contact with peers and for stable relationship-forming, respectively, are not met in childhood. This assumption is supported by the increasing number of studies showing high correlations between traumatic or emotionally stressful childhood experiences and psychological problems later in life.

Apart from being the root of the problems, the focus on needs also plays an important part in subsequent therapy. Maladaptive schemas hinder people from recognizing, experiencing, and fulfilling their own needs. One main goal of schema therapy is to help patients tune in to their own needs

and be able to identify them more clearly; the other is to help them meet those needs more adequately and appropriately, and to emotionally process the needs that were not met during childhood—and will never be met, since the patient is now an adult. The analysis of both current and past problematic situations focuses on the questions: Which needs of the patient are currently not fulfilled or have not been fulfilled in a given situation? How can patients improve their ability to fulfill these needs? It is important to note that nobody is able to fulfill all their needs in all situations and without any limits—this would neither be realistic nor functional. Psychologically healthy people are able to find a healthy balance between their own needs and the needs of others, as well as to estimate situational requirements. This includes knowing your own limits, therefore the need for realistic limits has to be fulfilled.

Placing human needs in focus is also an essential idea in other humanistic therapies. Conversely, it is very likely that every therapist refers in some way to a patient's needs. The difference in schema therapy, however, is that the patient's needs are addressed in a very explicit fashion and so an explicit reference to the patient's needs is integrated in all schema-therapy interventions. For example, imagery rescripting exercises (see Section 6.3.2) always follow the needs of the patient figure in the imagined traumatic situation, and chair dialogues (see Section 8.3.1) are used to defend the needs and the rights of the patient.

Young et al. (2003) defined five groups of basic human needs. Each schema domain is thought to be heuristically related to one of these groups (see Table 1.2). Like the list of maladaptive schemas, this list of human needs has been developed in everyday clinical work, and as such it is not derived from experimental research. It can be viewed rather as a clinical

Table 1.2 The relationship between schema domains and basic needs

Schema domain	Related basic needs
Disconnection and rejection	Safe attachment, acceptance, care
Impaired autonomy and achievement	Autonomy, competence, sense of identity
Impaired limits	Realistic limits, self-control
Other-directedness	Free expression of needs and emotions
Hypervigilance and inhibition	Spontaneity, playfulness

taxonomy with large overlaps with other theories of human needs, such as the approaches of Rogers (1961) and Grawe (2006).

As mentioned earlier, dysfunctional schemas develop when childhood needs are not appropriately met. Unlike other models (for example, Grawe, 2006), schema therapy introduces the assumption that there is a need for limits and discipline. If this need is not met, schemas such as lack of self-control/self-discipline and entitlement/grandiosity develop. This has not been empirically tested, but from an educational or parental point of view such a need is easily understood as important. Thus one can see that maladaptive schemas can either develop when needs are frustrated, particularly the needs for interpersonal closeness and safe attachment, or when children are spoiled.

In the course of therapy, the focus on needs is weaved into many interventions. An important part of psychoeducation is the discussion about how unmet needs in the patient's childhood laid the basis for his current problems. Later in life, schemas that are caused by unmet early childhood needs maintain the deprivation of the patient, since they usually prevent the patient from meeting their current needs, too. As a form of structured intervention, homework exercises or behavioral pattern-breaking techniques are prescribed, as they are thought to help the patient find ways of meeting their personal needs appropriately.

Case example: focus on needs in susan

Susan (see Section 1.1) had agreed with her therapist to start setting clearer limits on her ex-boyfriend and to discuss this issue in group therapy. However, she repeatedly failed to raise her hand in the group therapy sessions in order to talk about it. As a consequence, the therapist addressed this issue again in an individual session and highlighted how this avoidant pattern maintained frustrated needs in the patient. "Susan, I can perfectly understand how avoidance became the most important coping strategy during your childhood. When you were a child, the only way to survive was to avoid conflicts and stressful situations in your family. However, if you don't start reducing your avoidance today, I'm afraid that you will never learn to fulfill your very important need for setting your own limits. In the group therapy, you can easily learn how to talk about your own needs and your own concerns. You know the other

patients very well and you know that nobody will harm you in the group. Moreover, I will make sure that you will not get harmed again. I am completely convinced that the other group members will understand your problem very well. It might be a very positive experience for you to feel the support of the other patients."

1.3   Schema Coping

One schema can express itself in people with very different behavioral problems. The term "schema coping" describes how people deal with their schemas and how schemas become obvious in their interpersonal patterns. The schema coping concept is closely related to the psychodynamic concept of defense mechanisms. In schema therapy, we heuristically define three different categories of coping style:

Three coping styles

The coping style *surrender* means that a person acts as if the schema were true and surrenders into the subsequent behavior patterns.

When a person uses the coping style of *avoidance*, social situations and/or emotions are put aside by social withdrawal, substance abuse, and other avoidant behaviors.

Overcompensation means behaving in a very dominant and self-confident way, as if the opposite of the schema were true.

1.3.1   Surrender

With a surrendering coping style, a patient experiences schema-associated feelings very intensely and surrenders as it were to the "messages" of the schema, thus accepting them. In a surrendering coping mode, the patient behaves as if the schema was true and there was no other choice but to tolerate bad treatment by others. Typical examples of this coping style are

the subjugating patterns of patients with a subjugation schema and the frequent phenomenon whereby patients with severe sexual childhood abuse experiences tend to accept abuse in intimate relationships later in life as well.

Case example: surrender

Susan sometimes receives phone calls from her violent ex-boyfriend and then typically visits him and engages in a sexual activity, although she actually does not desire or wish for it. However, she suffers horribly from the lack of love and attention she believes she receives from everyone. When she engages in a sexual activity with her ex-boyfriend, she feels no arousal; however, she does experience at least a minimal amount of interpersonal warmth and affection. Nobody else is interested in her, anyway . . . Furthermore, she can hardly imagine expressing her own needs towards somebody else. She feels very anxious to do so but she is convinced that nobody would be interested in her needs.

1.3.2   Avoidance

We talk about avoidant schema coping when people avoid activation of the schemas or the emotions associated with them in order to protect themselves. The associated behavior patterns that are typical here are social withdrawal and avoidance or lack of emotional contact with others. In the therapeutic relationship, this coping style is activated when the therapist feels a lack of connection and contact with the patient. Beyond behavioral avoidance in the narrower sense, other behavior patterns can also be regarded as emotional avoidance and are thus considered to be related to this coping style. These include in particular substance abuse to avoid experience of and dealing with emotions. Sometimes patients keep themselves continuously occupied in order to maintain a constant level of stimulation, which helps them to avoid their current feelings. This might take the form of computer games, workaholism, television and the Internet, or overeating. When patients report the use of such activities to reduce feelings of anxiety and so on, we speak about an avoidant schema coping.

Case example: avoidance of a mistrust/abuse schema

Sabina, a 27-year-old borderline patient who was sexually abused as a child, says that she can hardly interact with men at all. Sometimes friends convince her to go to a party or a similar event which provides opportunities for interaction with men. When a man approaches her in such a situation, she feels panic and experiences being driven into a corner. Her initial instinct is to run away. Such emotions are typical for a mistrust/abuse schema. Often she copes with such situations by consuming a lot of alcohol. This mutes her feelings of desperation, although she still does not feel really safe, even when she is drunk. After the alcohol consumption, she is highly stimulated and feels less threatened. When under the influence, she sometimes engages in spontaneous sexual activities with men whom she has only just met. In these sexual contacts, she usually lacks any sort of feeling or emotion. So far she has never had sex in her adult life without having consumed alcohol. Sabina feels very ashamed about the alcohol abuse and the related sexual affairs. However, without alcohol she would hardly be able to relax. Even when she truly intends not to drink anything and stay sober at a party, she tends to consume alcohol after all, due to her unbearable emotions in these situations—if she doesn't simply cancel her attendance at the last minute.

1.3.3   Overcompensation

With the schema coping style of overcompensation, people act as if the opposite of the schema was true. People with a failure scheme, for example, might show off and talk excessively about their achievements. Somebody with a mistrust/abuse schema might behave in an overly self-centered and aggressive manner. Sometimes people with a mistrust/abuse schema who are overcompensating even abuse others in order to avoid abuse or threat against themselves. People who overcompensate for a subjugation schema may insist that others subjugate themselves to them and accept their ideas without discussion. In the therapy situation, overcompensation can be easily identified in the therapeutic relationship when the therapist feels dominated, driven into a corner, or even threatened by a patient. Patients with narcissistic overcompensation, for example, typically devalue their therapist,

provoking them by questioning their experience and qualifications, and so on. In contrast, people with an obsessive-controlling overcompensation mode might correct their therapist in a very detailed and rigid way. In both cases, the therapist feels controlled and devalued.

Case example: overcompensation

Nicole, a 25-year-old patient with borderline and antisocial personality disorder, experienced horrible sexual and physical violence during her childhood. From the age of 15, she took different illegal drugs, worked as a prostitute, and even became a perpetrator in violent offenses. In the therapeutic relationship, Nicole is mostly enraged and angry, behaving aggressively and attacking the therapist verbally. The therapist validates and stops Nicole's aggressive mode and starts exploring the feelings behind her wall of aggression. Nicole then starts talking about her feelings of being threatened by others and about her lack of trust. She believes that she will not be supported by others, even if she openly displays a need for it. Since she has never felt supported by anybody, she is not able to feel supported by her therapists and other medical staff either, although she is cognitively aware that these people are here to help her.

Unlike the actual schemas, schema coping can be detected and identified quite easily. Patients who come across as submissive and dependent, without focusing on their own needs, probably surrenders a lot when they feel the schema-associated emotions very strongly. Patients in whom the therapist senses a lack of any emotions and/or with whom they fail to establish an interpersonal rapport are probably in an avoidant coping mode. Overcompensation can be identified when the therapist (or other people of significance in the patient's life) feels dominated or threatened.

1.4   The Schema Mode Model

One particular schema can be connected to a range of different behavioral and experiential patterns, as has already been partly described in Section 1.3. For example, a patient with a strong failure schema may sometimes feel sad,

desperate, and helpless due to the smallest mistake he makes. On the other hand, however, he may at other times be in an overcompensation mode, trying to demonstrate his own achievements in a potentially exaggerated manner and denying any mistakes. Further, such a patient may sometimes also avoid situations related to achievement altogether in order to avoid the possibility of failure and its associated feelings.

Patients with personality disorders typically show specific schema-related behavioral patterns which interact negatively with therapy progress (just as they interact negatively with other life domains). A good example is the high social avoidance levels in patients with avoidant personality traits. Such patients usually only attend a few sessions with the therapist, maintaining a very limited interpersonal contact, since their avoidant coping style is very strong and is continuously activated in the therapy session.

In a similar way, patients with narcissistic overcompensation may constantly dominate others, both in the therapy session and in other life situations. In such cases, therapists have to take an active stand and play their role in therapy. However, in other patients, mainly patients with BPD, the situation is different—they do not show one enduring coping mode, but instead frequently change between different schema-associated states. Again, frequent changes of the emotional state may cause problems in therapy, because these changes are associated with changes in the patient's opinions and plans, as well as in their subsequent modes. While they may be very optimistic about changing a given problem behavior in one moment, they may feel absolutely incapable of doing so the next.

Case example: persistence of one coping state

Phillip, a 45-year-old computer programmer with narcissistic features, seeks psychotherapeutic treatment to reduce his social anxiety. He reports being very afraid of people. He actually hates interpersonal contact, since he continuously feels extremely insecure and devalued by others. The background to these feelings is quite unsurprising, as it stems from childhood trauma: when he was a child, he suffered from severe neurodermitis and was therefore bullied for several years by his classmates. He developed severe feelings of shame and still feels very easily ashamed and devalued today, even though the dermatitis remitted long ago.

Although Phillip talks about his anxiety, he comes across as a very dominant person. It can thus be deduced that he is in an overcompensating state. He speaks constantly, to the point that the therapist is hardly able to interrupt him. He talks about his prior treatments and therapies in a professional manner, as if he was discussing another patient and the therapist was a colleague. When the therapist makes a comment, he immediately interrupts and corrects her. He seems out of touch with himself, his social anxiety, and his therapist. After half an hour, the therapist feels dominated and frustrated. It seems to be impossible to talk with this patient in a normal way, so long as the overcompensating pattern is present. Although Phillip reports a severe defectiveness/shame schema, the therapist cannot perceive it in his behavior, nor sense such feelings in him.

In such cases it is an important principle in schema therapy to confront the patient empathically with his overcompensation very soon, and to work with this pattern to begin with.

Case example: frequent schema mode changes

Betty, a 39-year-old patient with BPD, has been in treatment for 15 months so far and has managed to build up a very close therapeutic relationship with her therapist. Today the therapist is a bit late for the session, and the patient is waiting in front of the therapist's office in a room without any chairs. When entering the room, the therapist notices some anger in Betty. The therapist addresses this anger, and Betty says, "It's all the same to you whether there's a chair in front of your ugly room or not, because *you* never need it!" When the therapist directly addresses her anger, Betty doesn't admit to it and calls herself "ungrateful," because she knows that the therapist is very engaged and she thinks that it's horrible to treat her in an ungrateful way and believes that she should not be angry at her. The therapist, however, disagrees, and validates Betty's right to become angry when her therapist does not arrive on time. Betty would not be an evil person for getting angry at her therapist. Betty, who feels quite safe in the therapeutic

relationship already, starts crying and says that she felt very lonely when she had to wait on her own in the unfurnished room.

The *schema mode concept* was developed to explain and describe such phenomena. A "schema mode" is defined as a current emotional state which is associated with a given schema. Schema modes can either change frequently or be very persistent. In patients with many different schemas and intense schema modes, it is often much easier to address these modes than to refer to the schemas behind them. Schema modes are divided into modes associated with mostly negative emotions and modes used to cope with these emotions.

1.4.1   Child modes

Child modes are associated with intense negative emotions such as rage, sadness, and abandonment. They resemble the concept of the "inner child," which is used in many therapies (such as transactional analysis). A patient with a mistrust/abuse schema, for example, may feel threatened and at the mercy of others when they are in the abused child mode.

1.4.2   Dysfunctional parent modes

The other category of highly emotional modes is the so-called dysfunctional parent modes. Conceptually, these modes overlap with the notion of (perpetrator) introjects in psychodynamic theory. In schema therapy, they are viewed as internalizations of dysfunctional parental responses to the child. In dysfunctional parent modes, people keep putting pressure on themselves or hate themselves. Patients with a mistrust/abuse schema, for example, davalue and hate themselves when they are in the punitive parent mode.

1.4.3   Dysfunctional coping modes

Coping modes are related to avoidant, surrendering, or overcompensating schema coping. In avoidant coping modes, people avoid emotions and other inner experiences, or avoid social contact altogether. In overcompensating coping modes, people stimulate or aggrandize themselves in order to experience the opposite of the actual schema-associated emotions. Phillip shows a strong overcompensating mode, for example, while Betty switches between different modes.

1.4.4   Healthy modes

Healthy modes are the modes of the healthy adult and the the happy child. In the healthy adult mode, patients are able to view their life and their self in a realistic way. They are able to fulfill their obligations, but at the same time can care for their own needs and well-being. This mode has conceptual overlap with the psychodynamic concept of "healthy ego functioning." The mode of the happy child is particularly related to fun, joy, and play.

Schemas are conceptually close to *traits*, while schema modes depict the schema-associated *states*. Schema modes are divided into the categories of

1. child modes,

2. dysfunctional parent modes,

3. dysfunctional coping modes and

4. the healthy modes of the healthy adult and the happy child.

Modes can be much more easily recognized and addressed than can schemas. Therefore, they are central to the treatment of difficult patients. In schema therapy using the schema mode concept, all therapeutic techniques are always adapted to the current emotional mode of the patient. It makes little sense to work on a mode that is not sufficiently activated, since new information will not affect it. Working on the current mode helps the patient to recognize and change both the schema mode and the actual schemas.

Case example: Phillip—confronting the overcompensation mode

The therapist first observes Phillip's overcompensatory mode for about half an hour and then directly addresses it: "Phillip, I understand that you suffer a lot from your social anxiety. However,

interestingly, I feel that right now, in our session, these fears don't seem to be present at all. Even when we directly address them, you seem to come across as very distant and dominant. This is in quite a contrast to the anxieties you report. I guess that you are exhibiting some kind of overcompensation. Do you happen to be familiar with the term 'overcompensation'? When you overcompensate, you behave as if the opposite of your problems were true. Over-compensation is meant to show others that you are cool, in control of the situation, and not anxious at all. What do you think about this possibility?"

Case example: Betty—different reactions to different modes

In the situation with Betty, the therapist focuses on validating the anger of the patient. Since the therapist knows Betty quite well already, she is aware of Betty's inability to allow herself to be angry with other people (demanding, guilt-inducing, and punitive parent mode). Therefore, the therapist tries to stop the punitive parent mode: "Betty, you do absolutely have the right to become angry when you have to wait unexpectedly in a dark corridor without any chairs! Your punitive parent mode is incorrect when telling you that you must not be angry with me!" Thus the patient learns to limit this mode herself in other domains of her life by internalizing the model of the therapist. Finally, during the course of the session, the therapist mainly focuses on feelings of sadness, which are related to the mode of the vulnerable child. A central idea of the schema-therapy model states that patients have to learn to accept emotional support (and learn to form safe attachments) in order to heal their schemas. On the level of therapeutic techniques, an imagery exercise focusing on the aban-donment feeling would be suitable. Alternatively, a chair dialogue focusing on expressing anger and limiting the punitive parent mode could also be suitable here.

The mode model offers a direct link to the current problems of the patient and to their interaction within the therapy session. It links different modes with problems and symptoms of the patient. In the following chapters, we will explain how patients' problems can be conceptualized within a mode case concept, and which intervention strategies are appropriate for which modes.

1.5 FAQ

(1) Why does schema therapy distinguish exactly 18 schemas? Couldn't there be 15 or 20?

The number and structure of the schemas is heuristic and has been derived from clinical observation. We actually do not have clear empirical support for the presence of exactly 18 schemas. Some authors and researchers did not find one or two of the 18 schemas, while others added one or two more. Taken as a whole, psychometric research in schema questionnaires shows an acceptable fit between the factor structure and the 18-mode concept (Oei & Baranoff, 2007). However, this cannot be found in all translations of the questionnaire. Thus it is possible that other factor structures could have a better empirical fit.

(2) What is the difference between schemas and basic assumptions?

The schema concept is broader than the concept of basic assumptions. While basic assumptions include primarily (conscious) cognitive aspects, schemas also include emotional, interpersonal, and other behavioral facets, as well as unconscious or implicit information.

(3) There seem to be hierarchical relations between different schemas. For example, there is a schema called "subjugation," but subjugation is also part of submissive schema coping. How do these different facets relate to each other?

The schema concept implies that all schemas exist more or less at the same level. However, some schemas seem to be more "primary" in nature, mainly those from the domain disconnection and rejection. Others, such as those in the domain other-directedness, are typically more "secondary" coping patterns. These relations have not been explicitly addressed yet. However, in the mode model, parent and child modes can be regarded as

primary modes, while coping modes are secondary patterns used to cope with the emotional pain connected with the parent and child modes. Thus the relationships between different schema modes are more clearly defined than the relations between different schemas.

(4) What's the exact difference between schemas and modes? Punishment can be a schema, but there is also a punitive parent mode. Is the differentiation necessary?

In some cases the two concepts of schemas and schema modes cannot be very easily separated. The main difference is that the mode model is always focused on different schema states (resembling the ego-state concept); these can be either intense emotional states associated with a schema or schema coping patterns, which are less emotional in nature. This differentiation is less important in the schema model, since schemas describe broad traits rather than particular states.

(5) What about positive schemas? Do they also exist?

The schema concept was first created in experimental psychology in order to describe information processing in psychologically healthy individuals. All people develop schemas during their childhood: representations of the world, the self, other people, social relationships, and so on. When children are raised by caring parents, they have a high probability of developing a self-schema of themselves as worthy, lovable persons and schemas of others as basically friendly and reliable (within realistic limits).

However, the concepts of schema therapy focus mainly on negative or dysfunctional schemas and modes, although in the mode concept the healthy modes of the healthy adult and the happy child are defined too—though they are less differentiated than all the negative and dysfunctional schemas and modes. However it is important to note that the mode concept can be integrated with many other approaches. Therapists may include positive schemas or modes depending on their preferred clinical approach. Within the schema-therapy approach as presented here, work on defining and testing positive schemas has just begun (Lockwood & Perris, private correspondence).