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Introduction

1.1 Different Perspectives in Couple Therapy

In the past years, in the field of couple therapy, a vivid discussion emerged around the polarity between therapies focusing more on *attachment* vs. those emphasizing *autonomy* too (Hardy and Fisher 2018). At first glance, the attachment-oriented perspective appears particularly convincing and has therefore become firmly established in both practice and research. Representatives of this approach view the promotion of a secure bond between partners as the key to a successful therapy (Johnson 2019; Gottman and Silver 2015).

In contrast, autonomy-oriented concepts highlight developing self-assertion and differentiation of each partner as a basement of a flexible and comprehensively satisfying relationship combining conjoint and individual growth (Schnarch 2009). According to Anderson (2020), however, the somewhat vague use of terminology has contributed to autonomy being marginalized in couple therapy—often because it is mistakenly equated with individualistic withdrawal or even with an aversion to closeness. On the surface, the two perspectives may appear contradicting. Lebow (2014) refers to the “attachment vs. autonomy” controversy as one of the central challenges for integrative therapy approaches.

At the same time, the wish for integration reflects the everyday experience of many psychotherapists. Pinsof et al. (2018), for instance, developed a meta-model that sets out criteria for merging different theories and strategies in a scientifically sound way. Like Perel (2017), we also see attachment and autonomy not as opposites but as complementary poles mutually fertilizing each other. Overemphasizing one side can unnecessarily restrict therapeutic work. From our perspective, schema therapy offers a particularly suitable foundation for integrating both perspectives. In simple words: *Who is overly self-absorbed may lose the other person, who is too much focused on the other person, may lose themselves.*

Before presenting this approach in more detail, we will first outline the two poles—differentiation and attachment—in order to clarify the framework of schema therapy more precisely.

1.1.1 Approaches Emphasizing Differentiation

More than 40 years ago, Bowen (1993) introduced the concept of differentiation to explain healthy functioning not only in individuals but also in couples, families, and even societies (Hardy and Fisher 2018, p. 560). Interestingly, the concept of self-differentiation includes both intrapsychic and interpersonal aspects. On the intrapsychic level, a high degree of differentiation means having a stable sense of self that can be maintained across changing contexts and important relationships. It serves as the solid, resilient foundation on both sides of the river upon which a stable bridge of relationship can be built. Interpersonally, differentiation means being able to live with both intimacy and autonomy. In close partnerships, this means being able to be separate without fearing abandonment and being able to allow intimacy without fearing enmeshment (Skowron 2000). This gives us a silver lining of the gain of integrating autonomy and attachment.

A prime example of an autonomy- and differentiation-oriented perspective in couple therapy is the work of Schnarch (2009), one of the world's most well-known couple and sex therapists. In his view, insufficient differentiation between partners leads them to base their self-worth and identity too much on the other's validation, which in turn puts a strain on the relationship. By contrast, Schnarch formulates the ideal of *wanting* a partner in freedom but not *needing* them (Schnarch 2009). Building on Bowen's model, he developed the "Crucible Four Points of Balance" as an individual foundation for a thriving relationship:

1. **Solid flexible self:** Being able to remain yourself even under external pressure, while at the same time being open to change if the partner's position or impulses are reasonable and convincing.
2. **Quiet mind and calm heart:** The ability to self-soothe and regulate strong emotions from an inner center—without dominating others or submitting to them.
3. **Grounded responding:** The capacity to react appropriately to provocation or difficult situations, neither through overreaction nor avoidance.
4. **Meaningful endurance:** On the one hand, this means committing to important goals even when it is painful and requires leaving one's comfort zone. On the other, it also means recognizing when efforts are fruitless and it is better to let go. In this way, orientation toward change is balanced with acceptance.

As the name suggests, these four aspects are meant to create an inner balance that provides the foundation for a cooperative, noncontrolling relationship built

on freedom and trust. This fully aligns with the approach we present in this book. From a schema therapy perspective, these four qualities correspond closely to the *healthy adult mode*, which we aim to strengthen in our work.

1.1.2 Approaches Emphasizing Attachment

At the root of attachment-focused approaches to couple therapy lies—unsurprisingly—attachment theory, most closely associated with Bowlby (1969). The starting point is the emotional bond between a child and a caregiver, which forms a lasting template for early relational experience (the *internal working model*). This becomes the lens through which all later relationships are unconsciously perceived, evaluated, and shaped.

Much like in childhood, three basic patterns or social roles can be distinguished in how people respond to a perceived threat of emotional attachment loss:

- with loud protest and compensatory demands for closeness (dominance or fight);
- with anxious-avoidant withdrawal (avoidance or freeze);
- or, based on a secure attachment, with a “mature” approach to the partner (prosocial engagement in terms of cooperation and connection).

This trichotomy is related to the polyvagal theory model (Porges 2011). Beyond this descriptive classification of attachment and interaction styles, one of the hallmarks of attachment research is its evolutionary grounding. This helps explain the intense emotions often seen in relationship conflicts: when attachment is threatened, old patterns (or schemas) laid down in the developing brain during childhood are triggered, flooding the person’s current experience. In these moments, the person is no longer acting as their adult self in the here and now but driven by a reactivated childhood state instead—the *child mode*. As a result, schema-driven individuals slip out of their normal social role. Without this background knowledge, it is difficult for their partners to make sense of such behavior or to respond appropriately. Our therapeutic task, for example, through joint imagery exercises (Module 9, Section 6.9), is to reveal the underlying childhood scene (Schema) driving the presented behavior. This enables the couple to “team” up against these “ghosts from the past” and strengthen their present-moment relationship.

The best-known and most extensively researched attachment-oriented approach is *Emotion Focused Therapy* (EFT) (Johnson 2019). Its core target is to foster secure bonding between partners. Conflicts are understood primarily as expressions of attachment fear or disappointment. Couples are supported in becoming more aware of these “primary” emotions and in expressing them directly and appropriately. The focus of the therapy is strongly on here and now. The therapeutic space

is designed to create an atmosphere of trust in which the couple can engage with each other's emotional experience, gradually breaking free from their negative interactional cycles.

Despite these differing theoretical emphases, practitioners are typically very integrative in their orientation. According to Hardy and Fisher (2018), most therapists draw on their own experience to combine both autonomy- and attachment-based perspectives. The art lies in using fruitful overlaps without denying the differences: *building bridges without watering down divergent positions is the true spirit of integration* (Hardy and Fisher 2018, p. 566). From our point of view, schema therapy—being integrative from the very start—offers a particularly strong paradigm for building precisely such a bridge in couple therapy.

1.2 Foundations of the Schema Therapy Model

Schema therapy was originally developed for people with chronic emotional difficulties and interactional problems (Young et al. 2003; Roediger et al. 2018a). Emerging from a close collaboration with Aaron Beck, schema therapy became increasingly integrative during the nineties of the last century, as Jeffrey Young drew on psychodynamic models while still maintaining his cognitive and behavioral roots. He incorporated other key concepts into his framework, such as object relations theory (Kernberg 1976), attachment theory (Bowlby 1969), and transactional analysis (Berne 1964).

In therapeutic practice, Young expanded behavioral methods by integrating experiential techniques—for instance, from *Gestalt Therapy* (Perls et al. 1951), psychodrama (Moreno 1946), and hypnotherapy (Erickson 1979).

A particularly important feature, in our view, is that schema therapy—with its psychodynamic elements—maintains a strong focus on biographical work. Early childhood experiences are seen as deeply formative in shaping later relationship regulation. In this way, schema therapy broadens and deepens the understanding of disorders beyond traditional behavior analysis. Unlike psychoanalysis, however, schema therapy focuses primarily on core human needs and assumes that persistent frustrations in these areas can leave lasting traces that manifest symptomatically in adulthood in a variety of ways. And finally, schema interventions are very goal-directed with a behavioral focus.

1.2.1 Early Maladaptive Schemas

Young assumed that children whose basic emotional needs (for attachment, autonomy and competence, appropriate limits, self-esteem, pleasure, and play)

are repeatedly frustrated develop so-called *early maladaptive schemas (EMS)* (Young et al. 2003, p. 36). Young defined a maladaptive schema as a “pervasive theme or pattern, comprised of memories, emotions, cognitions, and bodily sensations, regarding oneself and one’s relationships with others, developed during childhood or adolescence, elaborated throughout one’s lifetime, and dysfunctional to a significant degree.”

In more simple words: Schemas bear the essence of *scenes* or “video clips” of what happened to the child and how it experienced it, when its emotional core needs were not met. The *schema* offers a *name* for a specific *scene*.

For example, a child who repeatedly experiences rejection or abandonment by parents or other important caregivers has their need for secure attachment chronically frustrated. As a result, this person may develop an *abandonment* or *defectiveness* schema. Once activated, these schemas negatively affect current relationships by triggering hypersensitivity to real or imagined signs of rejection or abandonment.

Maladaptive schemas act like persistent perceptual and interpretive filters (“glasses”), distorting how later life situations or *scenes* are experienced and appraised. For instance, with a *mistrust* schema, the behavior of others may quickly be interpreted as “against me.” Schema activation is typically accompanied by strong, unpleasant emotions such as fear, sadness, or anger—emotions that often feel overwhelming. These, in turn, lead to maladaptive coping responses, such as lashing out at a partner with accusations and anger. Coping responses are considered maladaptive when they prevent the actual underlying need (e.g., for secure attachment) from being met in the present, thereby maintaining the schema over time and blocking corrective experiences.

Heuristically, Young et al. (2003) identified 18 maladaptive schemas, grouped into five domains (e.g., “Impaired Autonomy and Performance”), depending on which basic need was violated. A more detailed description of these schemas can be found in Roediger et al. (2018a). Table 1.1 provides an overview of the 18 established schemas and their respective domains.

More recently, an Australian research group reanalyzed the long version of the Young Schema Questionnaire (YSQ-L3) and, using Rasch analysis, proposed additional schemas (Yalcin et al. 2022). These include *punitive orientation toward others* and *fear of losing control*. Particularly the punitive-to-others schema is important for our model, as it underlies the externally directed critic modes (see Section 6.8).

Table 1.1 The 18 schemas, basic needs, and domains.

Nr	Schema	Child experience/reaction	Frustrated need
1	Emotional deprivation	Received too little love and affection in the presence of others	Secure attachment to others
2	Abandonment/instability	Left alone by caregivers, not properly cared for, leading to fear of loss	
3	Mistrust/abuse	Emotionally, physically, or sexually abused, now afraid of being exploited	
4	Social isolation	Excluded during youth, felt like an outsider, had few friends	
5	Defectiveness/shame	Was belittled or humiliated, feeling unlovable	
6	Failure (to achieve)	Lacks confidence in own abilities, avoids tackling tasks	Autonomy, competence, and sense of identity
7	Dependence/incompetence	Cannot make independent decisions, feels overwhelmed by everything	
8	Vulnerability	Fearful of the unfamiliar, feels defenseless and exposed	
9	Enmeshment/undeveloped Self	Very close attachment to parents up to parentification, unable to develop an independent identity	
10	Entitlement/grandiosity	Believes rules do not apply to them, feels superior to others, controlling, little empathy	
11	Insufficient self-control/self-discipline	Little persistence in pursuing goals, avoids complex tasks, reacts impulsively	Realistic limits and self-control
12	Subjugation/submission	Complies with others' expectations out of fear of rejection	
13	Self-sacrifice	Fulfills others' needs in order to receive affection	Freedom to express valid needs and emotions
14	Approval-seeking/recognition-seeking	Behaves in a conforming way, even to the point of self-denial, in order to be liked and belong	

Nr	Schema	Child experience/reaction	Frustrated need
15	Emotional inhibition	Controls feelings and spontaneous impulses in order not to stand out	
16	Unrelenting standards (perfectionism)	Very high standards for self and others, does not take breaks, perfectionistic/compulsive	Spontaneity and play
17	Negativity/pessimism	Always find faults, has difficulty making decisions	
18	Punitiveness	No tolerance for mistakes in oneself or others, harsh and unforgiving	

In addition, Arnoud Arntz and colleagues have suggested two additional core needs and associated schemas: *lack of a coherent identity* and *lack of meaning* (stemming from frustration of the need for self-coherence) and *injustice* (stemming from frustration of the need for fairness) (Arntz et al. 2021). There are certainly good arguments for adding these schemas. Fair enough, as mentioned in the introduction, however, taxonomies do not play a key role in our practical work. In therapy, we explore schemas individually through imagery and can assign them very specific, personalized names. After all, the aim of therapy is to help people deal with their own unique emotional wounds and the associated “schema pain.” In our view, taxonomies may provide some orientation but don’t contribute much to the therapy itself.

1.2.2 Schema Coping Styles

Situations similar to those that originally gave rise to a schema still trigger the same painful emotions today. To deal with this “schema pain,” people generally choose one of three coping directions. Which one they adopt depends on various factors, including temperament, personal resources, and their environment including role models. The options are:

- 1. Resignating to the pain (surrender):** People resign themselves to their role and stop fighting against it. In this way, they accept the “victim position.” While this spares them from exhausting, futile struggles, it also keeps them stuck in old patterns. They adapt their expectations to the situation, which may bring some relief, but at the cost of not using the greater possibilities available to them today.

2. Withdrawing from situations that might trigger the pain (avoidance):

In the sense of “better safe than sorry,” people withdraw from potentially painful experiences. The price is often a restricted and constrained life, with loneliness and missed opportunities. Still, some accept this, even though “more life” would be possible for them today.

3. Doing the opposite of the childhood experience (overcompensation or inversion):

This requires inner strength as well as an environment that allows—or even encourages—such behavior. People then proactively avoid schema activation by “turning the tables on others”: they show variations of dominant or controlling behavior to ensure they are not abandoned, shamed, abused, or deemed incompetent or excluded.

1.2.2.1 Schema Overcompensation, or Don’t Judge the Book by Its Cover!

Because of its importance for our work, we want to look at this third coping style more closely. People who overcompensate their schemas often present themselves in exactly the opposite way from how they felt as children when the schema was formed. The abandoned and unseen child, for example, tries to bind others to them and secure attention or affection, e.g., by clinging or off-showing behavior. The shamed child later seeks admiration. The powerless, helpless child strives for control. The child devalued as incompetent works hard to achieve outstanding performance in education and career. In short, such people tend to present “on frontstage” as proactive, in control, and even dominant. This is the behavior others see and react to. In our model (see Section 3.2), we describe these more externalizing individuals as “standing on the RED leg.”

Some people who overcompensate manage to “forget” their schemas and the associated pain to a large extent. In a sense, they “change sides” and can move from victims to offenders. This is often the case in perfectionistic or narcissistic individuals. In Module 5 (see Section 6.5), we describe how to bring such people—through an empathic yet confrontational approach—back into contact with this forgotten side, so they can build more flexible and fulfilling relationships.

Others remain inwardly sensitive to the schema pain in the form of vulnerability but try to hide it. Thus, this side is not visible from the outside. For these individuals, therapy focuses on showing them that their needs can be better met today if they act less controlling and dominant and instead allow more of their underlying vulnerability to be seen. Based on the embodied “CARE system” in all of us (Panksepp 2011), in functional (or tuned-in) partners, showing vulnerability usually elicits more support today than they ever received in childhood. However, this requires letting go of control and placing more trust in the present environment.

Metaphorically speaking, our goal is to “rewind the overcompensation video,” reconnect with the schema pain, and then “shoot a new video” in which the

adult person—with today’s strengths and skills—can find balanced ways of meeting their basic needs. Creating such experiences is the purpose of the modules described in Part 2.

1.2.3 The Mode Model

When a person has multiple schemas, it can become very complex to create a clear case conceptualization and a structured therapeutic plan based solely on the schema model. This is particularly true for people with borderline personality disorder. For this reason, Young expanded the schema approach by introducing the *mode model*, which has since become the basis for schema therapy case formulation and treatment.

A *mode* is defined as the current overall, while transitory *state* a person is in at a given moment. In other words, a mode is the visible tip of an iceberg, while beneath the surface lie the schemas, emotions, and Schema-coping impulses that are activated in that moment. *Schemas* and the coping strategies imprinted in childhood represent the more stable aspects of personality—they have the character of *traits* and form the “body” of the iceberg. They are not directly visible. What is visible are the modes—the tip of the iceberg—that appear situationally and temporarily as behaviors, often reflecting several simultaneously activated schemas. These modes, in contrast, have the character of states (Roediger et al. 2018a).

The mode model, therefore, shows how underlying schemas play out in a given moment. It highlights the distortions that arise when schemas and automatic coping responses are triggered in the present. Since human beings can display a wide variety of behavior patterns, an almost unlimited number of different modes could be defined. Edwards (2022), for example, describes more than 65 modes, and even that list is far from complete. To keep things manageable, however, we group all possible modes into four main categories, which also form the framework of our approach (see Figure 1.1):

1. **Child modes:** Child modes represent basic emotions (Ekman 2003). One is positive—joy or contentment—which arises when basic needs are sufficiently met. Four are negatively colored: fear, sadness, disgust/feeling annoyed, and anger. These serve as signals, indicating the frustration of basic needs. They are closely tied to biographical scenes (“video clips”) in which those needs were not met and may appear threatened in the present situation as well. In this sense, they act like the “red lights on the dashboard of our awareness,” urging us to act so that unmet needs can be addressed. Behind these emotions are the “unconditional” schemas of the first three domains in Table 1.1. Unconditional schemas mirror directly the child’s experience in a pure and universal way. They are the first signal of the body indicating need frustration.

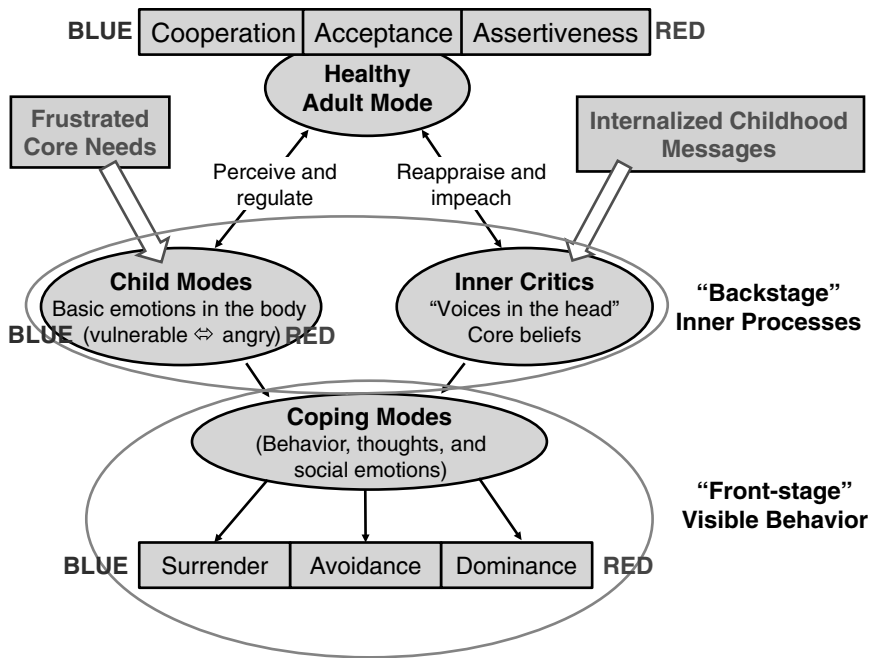


Figure 1.1 Dimensional mode model.

2. Dysfunctional beliefs/inner critics (formerly called parent modes):

These modes arise from internalized negative messages that children heard and integrated into their self-concept (internalization). They appear as self-critical, demanding, or punitive “voices in the head,” often inducing high levels of pressure and stress. The underlying core beliefs represent overarching standards, display rules, or dysfunctional values. They are stable (*trait-like*) and linked to the “conditional” schemas of the fourth and fifth domains. Conditional schemas are secondary and reflect social learning. We regard them as an interface between the schemas and the present moment thought of coping modes.

- 3. Maladaptive coping modes:** Coping modes can be seen as attempts to protect oneself from schema pain. They represent the strategies a child once used to survive difficult circumstances unfolding between the induced negative basic emotions (today appearing as child modes) and the pressuring internalized (inner critic) beliefs. However, these behaviors became frozen and are now applied automatically, without adjustment to adult resources and opportunities. What was once the best possible solution has thus become maladaptive in the present. They appear as changing *states* on “frontstage” composed

of (more or less) visible behavior, social emotions, and current (ego-syntonic) thoughts. As a result, basic needs remain poor or met in an imbalanced way. Since we usually only see the “frontstage” behavior—the coping mode itself—partners in a relationship mostly react to the visible “surface” rather than to the underlying schemas. This continues need frustration and perpetuates childhood suffering into the present.

4. **The healthy adult mode:** This mode symbolizes the healthy, functional part of the personality. Jeff Young (Young et al. 2003) called it “executive function” in charge to reevaluate and, if necessary, disempower the inner critic voices, while also recognizing and adequately meeting the basic needs of the child modes. This sets the stage for the happy child mode (basic emotion: happiness) to emerge.