Schema Therapy (ST) has evolved over the past 20 years to the point where it is now used both individually and with groups, with an emerging evidence-base for an increasing number of clinical presentations. It can be considered part of a broader trend in cognitive therapy which places a greater importance on information processing that is not readily available to conscious awareness (Edwards & Arntz, 2012).

Developed by Jeffrey Young, ST is primarily aimed at treating those who have entrenched interpersonal and identity difficulties associated with a diagnosis of personality disorder (Young, 1990). Individuals with more complex difficulties require the therapist to draw upon a wider range of techniques. ST combines aspects of cognitive, behavioural, psychodynamic, attachment, and gestalt models, and considers itself to be truly integrative, and continually evolving. Theoretical integration aspires to more than a simple combination of techniques, as it seeks to create an emergent theory that is more than a sum of its parts (Norcross & Halgin, 1997). Cognitive and behavioural techniques are still considered important aspects of treatment, but the model gives equal weight to emotion-focused work, experiential techniques, and the therapeutic relationship. Like cognitive behavioural therapy (CBT; see Chapter 4), it is structured, systematic, and specific, following a sequence of assessment and treatment procedures. However, the pace and emphasis on particular aspects of treatment may vary depending upon individual need.

6.1 Early Maladaptive Schemas

Young (1990) defines Early Maladaptive Schemas (EMS) as self-defeating emotional and cognitive patterns that develop early in childhood and are strengthened and elaborated throughout life. Maladaptive behaviours are thought to be driven by schemas. According to the model, schemas are dimensional, meaning that they have different levels of severity and pervasiveness. The more entrenched the schema, the greater the numbers of situations that activate it, the more intense the negative affect, and the longer it lasts. It is assumed that all individuals can relate to at least some of the schemas described in the model, although these are typically more rigid and extreme in individuals who seek psychological treatment.

Eighteen EMS are proposed in the model (see Young, Klosko, & Weishaar, 2003). By definition, they are dysfunctional and result in psychological distress. They are thought to be the result of both a child’s innate temperament and early experiences, and are accumulatively strengthened through ongoing negative interactions with others. In adulthood, the person engages in a variety of cognitive, affective, and behavioural manoeuvres which enable the person to maintain, avoid, and adapt to
their schemas in order to avoid experiencing overwhelming psychological distress. These coping styles take the form of Schema Surrender (giving in to the schema and accepting that the resulting negative consequences are unavoidable); Schema Avoidance (avoiding triggers internally and externally that may activate the schema); and Schema Overcompensation (acting as though the opposite of the schema was true).

6.2 Historical Origins of Schema Therapy

ST was Young’s attempt to address the needs of those for whom CBT was not found to be effective. The first form of the therapy, Schema Focused Therapy (SFT), was developed in the late 1980s and can be considered an adapted form of Cognitive Therapy (CT). SFT placed a greater focus on the childhood development of schemas (or core beliefs) and the therapeutic relationship, and included experiential techniques in order to target emotional change more effectively. The key principles of SFT were the identification of schemas, their developmental origins, and the coping strategies that develop in response to the presence of schemas. Intervention in SFT was based upon an understanding of how schemas and coping strategies impacted upon the person’s life and the therapeutic relationship.

By the mid-1990s, SFT was being applied to a wider range of clinical presentations, such as other personality disorders (Young & Flanagan, 1998) and eating disorders (Waller, Kennerley, & Ohanian, 2007); the model consequently evolved into Schema Mode Therapy so as to accommodate broader clinical complexity. While EMS are trait-like entities, that is, enduring features of the personality, schema modes are considered the state-like, changeable manifestations of schemas. Schema modes (see Young et al., 2003) are defined as ‘self-states’ that temporarily come to the fore and dominate a person’s presentation, and are made up of clusters of schemas and coping strategies. In clients whose personalities are poorly integrated, schema mode states can shift rapidly from one state to another. The concept of schema modes enables therapists to work with these sudden and extreme emotional shifts more effectively. Schema Mode Therapy, now known most commonly as Schema Therapy, has become the primary model most commonly worked with today (Young et al., 2003). There can be confusion between ST and SFT, as SFT is still referred to in a number of the key research studies – although ST was the preferred term adopted by the organisation founded to provide training and certification of the model, the International Society of Schema Therapy (ISST), in 2006.

In the early 2000s, Group Schema Therapy (GST) was developed for females with Borderline Personality Disorder (Farrell, Shaw, & Webber, 2009) and male forensic patients (Beckley & Gordon, 2010). Key features of the group approach are the utilisation of group therapeutic factors (Yalom & Leszcz, 2005), the facilitators’ roles as ‘co-parents’, and the group’s capacity to engage in experiential exercises which are both schema-activating and healing for all. Unlike some practiced forms of ‘group’ therapy,
GST is not simply individual therapy which the rest of the group observe; the group acts as an extended family, with members who are active in the intervention for each other as well as themselves.

6.3 Key Techniques

Whilst CBT aims to teach clients to manage their negative emotions through modification of cognition, ST uses experiential techniques to evoke affect as the therapist tries to bring about change in an emotionally connected way. In the beginning of the therapy, experiential techniques such as imagery re-scripting (Arntz & Weertman, 1999) and chair-work (Kellogg, 2004) are used more frequently in order to access the person’s core emotional experiences; in the later phases of therapy, there is a greater inclusion of cognitive and behavioural strategies to facilitate pattern breaking. Imagery restructuring and re-scripting are techniques commonly used in CBT for certain clinical presentations such as PTSD, Depression, and Social Phobia (Edwards, 2007; Grey, Young, & Holmes, 2002; Wild, 2009). Chair-work originates from the psychodrama work of Jacob Moreno and is a key technique in Gestalt Therapy (Perls, 1973). Therapeutic dialogues in chair-work take two forms. In ‘empty chair’ dialogues the person sits facing an empty chair and is asked to imagine a person in the opposite chair with whom they wish to converse. In the second form, the person moves between two chairs (or possibly more when working with modes) in order to play out an inner conflict (Kellogg, 2012). In schema therapy, this conflict is most commonly represented in schema mode dialogues. These techniques can serve as both cognitive and experiential in nature but, in ST, the focus is mainly on increasing emotional intensity, in order to increase the impact of schema healing work.

In ST, experiential techniques are used to go much deeper into unmet childhood needs and to enhance the use of the therapeutic relationship as the primary vehicle for change. It is not claimed that ST is unique in this, and there is evidence of a greater recognition of the therapeutic relationship in other broadly cognitive approaches (Gilbert & Leahy, 2007; see Chapter 10). In ST, the key relational strategies are ‘Empathic Confrontation’ – validating the development and continued perpetuation of schemas whilst simultaneously confronting the necessity to change – and ‘Limited Re-parenting’ – providing what an individual needed but did not get from their parents as children, within the boundaries of the therapy relationship. The experience of childhood is always present in the therapeutic dialogue. Even when the focus is on current issues, the aim is to understand the present in the context of the past. When the person is unclear why they are acting out in a particular way, the underlying schema or mode is traced back to its function in early life to cope with ‘toxic’ experiences, in order to facilitate understanding of the present.

A particular strength of ST is how easily the concepts are understood and emotionally resonate with clients. The key message is that distressing emotions in response to
current issues are directly linked to early childhood experiences, and that the strategies developed in order to cope in childhood are now problematic in adulthood. It is argued that the concept of schema is more effective at conveying emotional depth as opposed to a term like “core belief”, which does not capture the potency of the person’s experience. Diagrammatic formulations are useful for conveying the therapist’s understanding of the client, and the inclusion of images to represent the different modes can be particularly effective. Making use of such diagrams in-session can facilitate both client and therapist understanding of what is happening in the moment.

6.4 Goals of Schema Therapy

The overall aim of ST is to develop the person’s Healthy Adult Mode, which is understood as fundamentally changing aspects of personality functioning. This role is modelled by the therapist in the early stages of therapy, with the therapist gradually reducing their ‘active parenting’ over the course of therapy as the client develops autonomy in this regard. The goals of therapy are met when the client is able to achieve the following tasks:

1. Manage the emotional impact of early unmet needs, understood as the client being able to care for their own Vulnerable Child Mode.
2. Reduce the need for maladaptive coping modes, so that the client is able to tolerate connection with their emotional world without detaching or compensating for the effect of such connection.
3. Set limits upon the expression of anger or impulsivity in order to be able to express and assert their emotional needs effectively.
4. Reduce the intensity of self-punishment and criticism as conceptualised by the Punitive or Demanding Parent Mode, so that the client becomes able to hold onto compassion for themselves and others, has permission to make mistakes, and forms realistic expectations.

6.5 The Schema Therapist

The personal qualities of the therapist are of importance in ST. A good ST therapist should not be resistant to feeling personally affected by their therapy with clients, and emphasis is placed on their capacity to maintain a limited re-parenting stance. Limited re-parenting is considered the ‘heart’ of ST (Farrell, Reiss, & Shaw, 2014). Therapists who are most comfortable with a structured, predictable protocol are usually not well-suited to ST. The approach requires constant adaptation and responsiveness, based on the formulation of the person whose presentation can change moment-to-moment. To create a re-parenting bond, it is vital that the therapist can be openly warm and caring – i.e., comfortable in sharing these feelings with the client. Physical
touch is considered acceptable, but not essential; clearly its use needs to be carefully considered and may not be appropriate with certain clients or in specific settings. The ST therapeutic stance requires the person to have a clear understanding of their own emotional needs through the formulation of early experiences and schema development. The principle of ‘complementarity’, the process by which an individual’s behaviour can ‘pull’ the other into a familiar pattern of interacting (Safran & Segal, 1990) is central. Within the ST model, this has been described as ‘schema chemistry’ and is understood as the interpersonal activation of schemas between individuals. This can impact on the therapist-client fit when the therapist’s own schemas become activated by the interpersonal schema-driven patterns of the client. Schema chemistry is also a very useful concept in understanding the patterns of interaction which take place within mental health inpatient environments (Beckley, 2011) which is an aspect of the case study presented here.

6.6 Who Does it Work for?

ST was initially developed for treating Borderline Personality Disorder (BPD), but it is now also being used with a wider range of clinical presentations – although the evidence-base for its application outside of BPD is in its infancy. Most of the evidence thus-far has been generated for clients with BPD. Initial evidence emerged from a single-case design series, showing a significant reduction in EMS as measured on the Young Schema Questionnaire-2 (Young & Brown, 1994) and improvements in secondary outcome measures (Nordahl & Nysæter, 2005). Limitations of the study included the lack of independent evaluators and difficulties of generalising to a larger group from a single-case design.

A multi-centre trial in the Netherlands found that ST led to recovery from BPD in about half the sample, with two thirds experiencing a clinically significant improvement (Giesen-Bloo et al., 2006). ST was found to be approximately twice as effective as Transference Focused Therapy, and despite being a long term, high intensity intervention, ST was also found to be less costly and to have a much lower drop-out rate. The paper highlights the particular benefits of ST being: the transparency of the model, the re-parenting attitude of the therapist, clearly defined techniques, and the possibility to contact the therapist between sessions. A subsequent study demonstrated that ST was as effective in clinical practice as the findings in the RCT, and that the availability of telephone contact with therapists out of hours was not essential (Nadort et al., 2009).

A recent RCT demonstrated that group-based ST was an effective treatment for women with BPD (Farrell et al., 2009). Those receiving ST had lower scores on measures of BPD and higher scores on assessments of global functioning; differences were clinically significant, and sustained at six-month follow-up.
There is some evidence to suggest that ST can be useful in the treatment of Axis I disorders, particularly in the context of more complex presentations and where first-line treatments have proven unsuccessful. Ball (1998) developed Dual Focused Schema Therapy (DFST) for the treatment of substance abuse and comorbid personality disorder and evidenced its effectiveness in comparison with standard group counselling in two small-scale RCTs (Ball, 2007; Ball, Cobb-Richardson, Connolly, Bujosa, & O’Neill, 2005), although those with more severe personality disorders gained more benefit from standard group counselling. There is also an emerging body of single-case study evidence for ST across a range of clinical presentations (Bamelis, Bloo, Bernstein, & Arntz, 2012).

### 6.7 Criticisms of Schema Therapy

Perhaps one of the greatest limitations for ST in the UK, in the context of a resource-limited National Health Service (NHS), is the length of treatment that the approach requires. However, research is needed to establish the economic benefits of providing longer term psychological intervention for those clients who, given the nature of their enduring difficulties, often require inpatient treatment, lengthy community mental health care, or welfare support – and may come into contact with the criminal justice arena. The additional ‘strain on the surroundings’ (van Asselt & Bloo, 2012) in terms of informal support from family or friends is a further cost which is not well understood. Van Asselt et al (2008) were able to establish that ST was more cost-effective over a period of three years in comparison to treatment-as-usual. Studies comparing short-term psychological interventions (20 sessions or less) – which are most commonly offered to individuals with complex psychological difficulties – with longer-term therapies, such as ST, may have a greater bearing on how treatment is offered in the most cost-effective way.

James (2001) outlined some specific concerns in relation to the increasing use of ST, mainly pertaining to unskilled therapists using techniques which were outside of their range of competence, and ST being used as a panacea for a range of Axis I problems where CBT has already evinced effectiveness. There is merit in the criticism that the model can appear deceptively simple in theory, but the delivery of ST with complex challenging clients requires a high level of expertise or supervision from a certified therapist (e.g., for those embarking upon training in the model).

To summarise, schema formulation involves the establishment of patterns between early unmet needs and current difficulties, conceptualised by schemas and modes. The aim is to understand the function of current coping strategies in this context, and how they maintain the underlying schemas, and repeatedly elude emotional distress or detachment. This enables the therapist to effectively target the core unmet needs of the client, with the aim of reducing schema intensity and,
consequently, the need for the coping strategies. The therapist looks for themes which persist over time and in different relational contexts to aid this process.

6.8 Formulation in Action

The case description conveys that Molly experiences a deeply-held sense of worthlessness (Defectiveness/Shame) and that she does not fit in anywhere (Social Isolation). Molly infers that social groups make her anxious and she prefers indirect forms of communication. Perhaps most poignant, is the prevalent theme that she is not valid or important to others, and that her needs do not matter (Emotional Deprivation). There is evidence of her feeling compelled to act in a compliant manner in relation to her parents (Subjugation), which suggests she is dissatisfied with her ability to assert her needs. This would be considered worthy of further exploration as the client’s current relationship with her parents may be indicative of patterns of interaction established from childhood. Molly makes unfavourable comparisons with her sister, both in terms of her achievements (Failure) but also her sister being the favoured child (Defectiveness/Shame). Love and approval appear to be conditional within the family, particularly in terms of her mother.

Molly’s relational template is further influenced by her observation of her parents’ relationship. She portrays a significant emotional distance existing between them, with virtually all emotional interaction being suppressed other than critical comments made by her mother. Molly appears to have a greater need for emotional expression than other members of the family; as a consequence of her parents’ response to this, her need is experienced as a problem, and leads Molly to internalise her distress (Emotional Inhibition). Molly appears to have apportioned blame to herself for not meeting familial norms – with only fleeting evidence of her anger towards others. This would be an area for further exploration, as appropriate expression of anger appears to be an unmet need for Molly. Molly’s physical complaints may relate to her frustration in not being able to communicate her emotional needs, and so they manifest as physical problems which require attention and intervention. This is linked to her sense that her emotional needs are unimportant and that physical problems are more likely to receive a response from others.

Molly’s sense of herself as a problem and others as uncaring or uninterested is also evidenced in relationships outside of the family. In peer relationships, she describes herself as controlling and emotionally demanding. Further exploration would be needed to confirm the primary function of this, but her early history would suggest that this is a compensatory strategy which manoeuvres others into a position of rejecting her; likely to be reinforcing of her underlying schemas of Defectiveness/Shame and Emotional Deprivation. In ST, these schemas resulting from unmet needs represent the Vulnerable Child Mode, and they steer the direction and focus of therapy.
Molly’s mother appears to be the primary attachment relationship from which the Punitive Parent Mode has developed. Love and praise were contingent on Molly behaving in ways acceptable to her mother, often with a focus on academic attainment – and other aspects of her are ignored, dismissed or actively discouraged. It would appear that Molly was partially able to manage the expectations of her mother by making herself useful, not making emotional demands, and achieving academically. However, this was achieved to the detriment of Molly’s sense of personal worth – i.e., at the cost of being accepted for ‘who she is’ – and interaction with others created too much anxiety for her as to ‘how to behave’. There is a sense that Molly’s Punitive Parent Mode is very active at such times, berating her internally for being attention-seeking or a burden to others. Her father is somewhat absent in her narrative and this relationship warrants further exploration.

In adulthood, Molly’s Detached Protector Mode comes to the fore when she expects to be criticised or ridiculed by others, representing a generalisation of her maternal relationship. This results in her socially and emotionally withdrawing in order to protect herself. She considers herself to be flawed and unacceptable to others, seeing herself as a “burden”, and so turns down invites to social activities. This in turn results in fewer invites being made, and reinforces her underlying schemas; it is seen as evidence to support her perception that others are critical of her, and that this is pervasive across familial, social, and work relationships. There is a repeating pattern of social avoidance in response to this perception. The incident with Jack is an example of this: she feels stupid, and perceives her housemates, including Jack, to be rejecting of her, and she experiences a high level of shame. Her relationship with Danny is indicative of an underlying Abandonment/Instability schema, where the person forms intense relationships which ultimately result in them being rejected. This is worth further exploration although her account of her early experiences indicates that other (aforementioned) schemas could account for this relational pattern. It would be interesting to explore the reasons for Molly switching between avoidant and compensatory relational strategies in different contexts.

Exploration of Molly’s relationship with her sister Ella may prove useful. Ella is considered the ‘favoured’ sister in Molly’s mind, despite behaving in ways which one would assume their mother would disapprove of. Ella is one person that Molly is openly critical of, and it is possible that she is envious of Ella’s apparent self-confidence and success – feeling inhibited from being able to ‘please herself’ in a similar way.

Molly’s time in hospital parallels her early experience of family. She is accused of being dramatic and attention-seeking in her expression of distress, alienating some of the staff. Her self-harming behaviours can be understood as attempts to communicate distress and elicit support from others, but her methods of doing so result in rejection and resentment from some staff. This is a common response to behaviours understood as ‘attention-seeking’, often because the staff themselves feel helpless and unable to provide adequate care. Other staff are able to connect with Molly’s
underlying vulnerability, and so relate to her in a more empathic manner. ST would understand these differential responses in schema-mode terms, as differential connections with the modes or ‘parts’ of the person as if they were the ‘whole’ person. It is not clear which mode Molly was in when she took the overdose of pain killers. If it was an attempt to numb her emotional pain, it may represent an avoidance strategy; but, if her motivation was to seek care or attention from others, it might be better understood as an over-compensatory strategy. Certain nursing staff experienced this as a manipulation of them, rather than the behaviour being understood as a communication of Molly’s genuine emotional need, and so Molly is further invalidated by her experience of in-patient treatment.

Molly’s presentation at interview demonstrates very strongly the Vulnerable Child-Punitive Parent Mode interaction being played out. She initially presents in Angry Child Mode, where she is expressing her anger and distress at being ignored as she experiences it. This could be understood as evidence of a Punitiveness Schema, suggesting she sees herself and others as needing to be punished harshly for their mistakes. However, this cannot be assumed on the basis of her observed responses, as it may alternatively form part of a compensatory strategy: being critical of others as a way of receiving confirmatory criticism of herself as a response. Molly appears to revert back to self-blame very quickly and so the latter is likely to be the case.

Molly’s disclosure of sexual abuse would certainly be explored further and provides further evidence that Defectiveness/Shame is likely to be a key schema. She alludes to sexual problems being far more significant than is suggested previously. This may well be a core theme in her treatment but the therapist needs to be mindful not to assume which aspects of Molly’s early experience are of primary importance without careful exploration.

Molly’s goals are other-directed and vague. This is not unusual and collaborative formulation would assist with some further clarification. In ST, imagery techniques would be useful to help her connect with the core unmet needs which structure and drive the therapy process. If psychiatric diagnosis was considered important to Molly, we may initially conceptualise her difficulties as Avoidant Personality Disorder (American Psychiatric Association, 2013). In terms of Axis I problems, Major Depressive Disorder may feature. However, further assessment would be required to clarify the core schemas at play, deepening the understanding of repeated patterns in different aspects of Molly’s life, in order to fully appreciate the level of difficulty she may be experiencing. This is particularly important when considering whether somebody would meet the criteria for a diagnosis of personality disorder as, if the difficulties were in one domain of a person’s life, this would not be an appropriate conceptualisation; that said, the information provided in the case description is adequate for developing an initial formulation from a schema perspective.
6.8.1 Schema Formulation

Molly describes a childhood characterised by fear of abandonment and rejection by others, and a sense of herself as worthless and unlovable. The family environment can be described as emotionally inhibited, which exacerbated Molly’s sense that she was often in the wrong or in trouble for causing some form of irritation or inconvenience to her parents. These experiences are characterised by Defectiveness/Shame, Social Isolation/Alienation, Emotional Deprivation, and Emotional Inhibition. These Schemas are considered to represent her primary unmet needs and are conceptualised as the Vulnerable Child Mode. In response to these unmet needs it would appear that Molly may have felt anger towards others but that this anger was severely restricted in expression by the emotionally-inhibited environment and her fear of being rejected or criticised. There is a sense that her mother was the most powerful parental figure in the home, as the father is hardly mentioned – and only then in response to her mother’s treatment of him. Molly may have developed a more expressive Angry Child Mode had she been in different circumstances, but instead has suppressed her emotional needs in response to the value that she sees others put upon them. This mode briefly appears on occasion. There is an absence of the Happy Child Mode in Molly’s narrative; it is not clear that she has had the opportunity to experience important social and personal development opportunities that we associate with a happy childhood, and this will be an important focus in therapy.

Molly has a well-developed Punitive Parent Mode which appears frequently in her own narrative; berating her for having emotional needs, for not being stronger, and for being a burden on others. This is likely an internalised experience of her mother’s treatment of Molly and there does not appear to be a protective paternal influence upon this, leaving Molly to cope with this herself.

There is evidence of Molly flipping between all three coping styles. Molly has tried hard to meet the expectations that her mother has of her – such as doing well academically, not creating a fuss, and managing her own problems – and this reflects her Compliant Surrender Mode. This mode represents Molly’s attempt to feel love and approval from her mother, but appears to be ineffective. Her most prevalent coping style is one of avoidance; she quickly tends to distance herself from peers and engage in solitary hobbies or activities in order to protect herself from further criticism and rejection. There are numbing or soothing elements to some of her preferred activities, such as cleaning and the use of prescribed medication, which may function to reduce the Punitive Parent-Vulnerable Child interaction in her mind. This is best conceptualised as her Detached Protector Mode. Her goals are other-focussed and there is a likelihood that she does not have a clear sense of who she is or what she wants, indicating an underdeveloped sense of self. Molly can also act in an overcompensatory manner, being overbearing and clingy in relationships. This appears to be most likely to occur when someone has shown an initial interest in her, which she is not able to tolerate due to suggesting she is worthy of love or attention, and so she acts in ways
which result in her being rejected or criticised, reaffirming the ‘truth’ of the underlying schemas. Her attempts to control her eating can also be understood as a compensatory strategy: as an attempt to manage her sense of defectiveness. These strategies are ineffective in meeting her emotional needs, and so Molly’s sense of hopelessness and worthlessness increase and maintain her sense of self and others.

**Figure 6.1:** Diagrammatic Formulation

### 6.8.2 Intervention Objectives

Schema Therapy would begin with an extended assessment phase which would involve the use of experiential techniques in order to fully explore the links between Molly’s past and current issues. The formulation is used in conjunction with these techniques as a basis for understanding how the modes interact and relate to each other. Based on the material presented, the therapist would be paying particular attention to the Vulnerable Child-Punitive Parent interaction, to increase awareness of this mode and its significant impact upon Molly’s sense of self. The therapist needs to create a safe space for Molly to start to express her needs, whilst actively working on minimising the ‘interruptions’ of the Punitive Parent and by acting as a good parent, through praise, encouragement and validation. Molly needs to be able to connect with the therapist in this way before the other modes can actively be worked
upon. Lockwood and Shaw (2012) highlight the impact of children who have been ‘play-deprived’ and how therapeutic play can be incorporated into experiential work to give the client permission to explore their emotions safely. Examples of how Molly could be encouraged to connect with anger include popping balloons, drawing, or a tug of war game, all of which involve permission-giving, laughter, and praise for having an emotional presence.

Once the necessary safety and trust is established, Molly can begin to explore the key childhood memories and experiences which resonate with current difficulties. Every opportunity is taken to use language and techniques which provide re-parenting interaction based on the unmet needs of the person. In Molly’s case this would require a focus on the validation of her own worth and support with the expression of her needs – and for these to be listened and attended to. In imagery re-scripting, Molly would use current issues to ‘track back’ to their childhood origins, where there is the opportunity to replay these memories in a way which directly addresses her needs in that moment. Similarly, a focus of imagery re-scripting would be to develop and encourage Molly’s Happy Child Mode, to provide repeated imagery experiences for Molly of having her needs both valued and met. Another experiential technique which may be useful with Molly would be to construct a ‘no-send letter’ to either/both parents in order to build her confidence in emotional expression.

The aim of this earlier phase of therapy is to build Molly’s resilience and confidence, embodied by the Healthy Adult Mode. The repeated experience of experiential work aims to enable her to feel more able to deal with her current difficulties. As therapy progresses, the focus starts to shift onto the use of maladaptive coping modes in her adult life; continuing with the experiential techniques for this purpose, but also introducing cognitive and behavioural strategies to help Molly strengthen her Healthy Adult Mode outside of therapy. This can involve the use of diary cards, to track schema/mode-activating events, and the development of flashcards, to support Molly in remembering key therapy messages at times when her Vulnerable Child is most likely to be triggered. These cards could also serve as transitional objects to help Molly keep the therapist ‘in mind’ when the Punitive Parent Mode is active. Cognitive techniques can be useful in supporting the schema-healing process of the experiential work. Homework features in Schema Therapy but its use depends on the needs of the client. Molly could be set tasks which require her to practice expressing her needs, being assertive with her parents, and, in particular, being compassionate to herself. Depending on the goals set regarding social and relational contacts, Molly would be supported to take gradual steps towards managing her coping strategies differently and to approach feared social situations. In contrast to shorter-term therapies, this behavioural pattern-breaking work is often left until the latter part of therapy, so as not to place too many expectations on the client to have a Healthy Adult mode that is capable of such tasks. A primary therapeutic message is that change needs to be aimed at meeting Molly’s needs and is not about pleasing others; helping her
redistribute and re-allocate a sense of responsibility – and even blame, where appropriate – equally to other people or events in her life.

6.8.3 Challenges in Therapy

A particular difficulty which may arise is Molly’s tendency to please others. Therapists are often less aware of over-compliance than they are of conflict in therapy, as it can appear as if the intervention is going well. This would be openly discussed with Molly using the formulation, and both therapist and client would be encouraged to take responsibility for noticing the Compliant Surrender mode at play. Ways to consider managing this include providing more than one option for intervention strategies, being mindful in imagery re-scripting to offer choice, and to gradually increase Molly’s sense of autonomy and control over the direction of re-scripting when this is developmentally appropriate.

Molly is also likely to find it difficult to assert herself with the Punitive Parent Mode. For many clients, this mode is so intrinsic that they can find it hard to separate out the ‘inner critic’ from themselves. This is why experiential techniques such as chair-work can be particularly helpful, as this part of the person can be physically separated and distanced in the room. Once this has been achieved, Molly can be supported by the therapist to assert herself. It is important to distinguish this mode as originating from a critical or abusive parent, but that the mode is not actually the parent. Molly is likely to struggle with the concept of ‘banishing’ her mother, as she still has a relationship with her, and her mother is likely to have some positive influence in Molly’s life. However, it is necessary for Molly to be able to more accurately apportion responsibility for her current difficulties if she is to make progress in building her Healthy Adult Mode. An important aspect of therapy would be to enable Molly to express anger or frustration. The therapist can use naturally occurring events in therapy, for example, being late or making a statement which Molly finds invalidating, to encourage Molly to express such feelings, and to experience apologies from the therapist and affirmation that her needs are important. Molly is likely to find this very difficult initially but it is important to persist with this endeavour.

6.8.4 How is Effectiveness Evidenced?

Successful intervention is ideally based on a thorough analysis of the goals set at the start of therapy. Goal attainment scaling (GAS; Kiresuk & Sherman, 1968) can be a useful to monitor emotional, behavioural, and cognitive changes over the course of therapy. There is no measure of schemas that fully incorporates their multiple elements; the YSQ-L3 (Young & Brown, 2003) is the latest version of the Young Schema Questionnaire and mainly taps into the cognitive ‘core belief’ aspect of schemas. Other
tools include the Young Parenting Inventory (YPI; Young, 1999); Young-Rygh Avoidance Inventory (YRAI; Young & Rygh, 1994), Young Compensation Inventory (YCI; Young, 1995) and the Schema Mode Inventory (SMI; Young et al., 2007); all of which purport to measure aspects of the person’s functioning in relation to the ST model. These measures are considered to complement a comprehensive clinical assessment and therefore have utility in assessing outcome. Sheffield and Waller (2012) provide a useful guide to the use of these tools in clinical practice and highlight that a reduction in scores on measures is not necessarily an indication of good clinical outcome.

In RCTs, effectiveness of particular interventions is sometimes judged on the basis of individuals no longer being considered to meet diagnostic criteria. However, diagnostic criteria and quality of life are two distinct constructs – and meaningful therapeutic benefits to quality of life may be achieved without any change in diagnostic classification. Additionally, alternative measures, such as measures of self-esteem, may complement behavioural evidence for change. Primarily it is the view of Molly – and the positive changes she makes in terms of therapy goals – that is the most valid indicator of therapeutic success. Based on the formulation, one would hope to achieve changes in Molly’s ability to express and assert her emotional needs, to experience relationships with others as mutually fulfilling, and for her to experience occupational and social activities in more positive terms. Overall, from the material provided, Molly would be considered an ideal candidate for ST.

Aidan J P Hart

6.9 Schema Therapy Formulation: Critical Commentary

As I understand it, the Schema Therapy (ST) model places the origins of the client’s distress within Early Maladaptive Schemas (EMS) – which are unhelpful ways of interpreting the world – and how these manifest in unhelpful ways of being in the world (maladaptive Schema Modes). EMS are themselves contingent upon negative early life experiences.

On the face of it, from a behavioural perspective, this makes sense. Early negative experiences shape up particular behaviours via direct conditioning and indirectly through rule-governed behaviour. Within such contexts, a child may learn basic avoidance-based coping. Problems arise as they get older and encounter similar situations where previously conditioned responses are now elicited in the present (e.g., via stimulus generalisation). It is likely that such behaviours will be avoidance-based (i.e. negatively reinforced) coping strategies that bring immediate relief but also delayed aversive consequences. Due to a human propensity to be more influenced by immediate over delayed consequences, the short-term avoidance is more likely to remain a part of the behavioural repertoire. This keeps the client stuck in self-defeating attempts to escape their own distress.
Whilst there are aspects of the model I can relate to, I did see what I thought were some limitations of the approach, pertaining to its inchoate evidence-base and focus on nomothetic categorisations/the concept of ‘schemas’. Moreover, I found myself questioning whether ‘schema’ or ‘schema mode’ constructs are actually necessary within the approach; what do they add to the formulation?

6.9.1 Evidence-base

The approach is primarily designed for clients with a personality disorder diagnosis, with some recent attempts to apply it to other diagnoses. Considering that the approach has existed in published form for over 25 years, I was surprised at the lack of published empirical research on either outcome efficacy or theorised mechanisms of change (component analyses, for example).

I was further surprised at the lack of recognition of limitations of available outcome research. Some studies cited in the chapter had been previously reviewed by Masley, Gillanders, Simpson, and Taylor (2012) and found to be of a good standard (such as Giesen-Bloo et al, 2006). However, others (such as Farrell, Shaw, & Weber, 2009) drew more criticism; in particular, for failing to control for confounds between the ST and control (treatment as usual) groups. The lack of evidence, and the lack of recognition of limitations in the evidence-base, seemed to be a weakness.

6.9.2 Categorisation and the Concept of Schemas

Reading the chapter, I was struck by the pseudo-diagnostic categorisations and infantilising jargon (‘punitive parent’, ‘vulnerable child’) that ran through the description. EMS were discussed as if they are real and tangible things that inhabit individuals. This seemed to shift the focus onto things that people ‘have’ at the expense of the things that have happened to them. Explaining behaviour through schemas (which are behaviours themselves) leaves us with the added question of what is the context (i.e., an interaction with the environment) in which schemas are formed, elicited, and maintained. This surely brings us back to a focus on what has happened to the client through their lived experience of the world. Whilst ST does appear to attend to this, I am unsure what pseudo-diagnostic categorisation adds to the process. In this regard, the concept of EMS seems an unnecessary level of complication and a distraction from the variables influencing the client’s distress.

Claims were made about the nature and prevalence of EMS that seemed to be unfounded and/or irrelevant to the model:
1. It is assumed that everyone to some degree has EMS. Despite the model existing in published form for over 25 years, there is no evidence that this is in fact the case and this assumption remains entirely untested and without foundation. Given
that Schema Theory originated as a model of personality disorder and research has found personality disorder to have a weighted population prevalence of 4.4% (Coid, Yang, Tryer, Roberts, & Ullrich, 2006) this seems like a fanciful claim.

2. A worrying implication of the ‘everyone has schemas’ assumption is that those who score minimally on a measure such as the Young Schema Questionnaire can be dismissed as being in some form of denial or protecting themselves via some form of Schema Mode. This seems to make any formulation based upon the model dangerously unfalsifiable, with no way to refute the therapist’s analysis.

3. Despite the concept of EMS and Schema Modes being central to the model, there is no evidence presented as to their relation to distress. The notion that schemas drive the very behaviours we use to infer the existence of schemas seems like circular reasoning.

4. There is confusion in the model in that the shift from EMS to Modes in ST clearly suggests that EMS are not of central importance, yet EMS still form part of the definition provided for Schema Modes themselves.

5. Schemas seem unrelated or unnecessary to the formulation of distress. It is one thing to highlight a history of abandonment in significant relationships and an expectation that this will be repeated, but there is little evidence to support the notion that a person has an ‘abandonment schema’ residing somewhere inside them and that such a notion adds anything to treatment.

6. Whilst it is well documented that early experiences are influential in human development, the concept of EMS seems to imply that there is a mythical stage where things are set in stone. While this seems like an attractive proposition, it leaves little room for considering the impact of later events on psychological well-being and leaves the therapist to offer the unfalsifiable position that the reaction to later events is contingent upon the already identified EMS.

6.9.3 Comparison to ACT Formulation

Despite my concerns above, I was struck by the similarity in the formulations and the interventions across the two models. Both had an appropriate focus on what Molly had learned about the world and a focus on helping Molly break down ineffective patterns of avoidance. The one difference I would note would be on ACT’s focus on Values and Committed Action. Whilst I could see this possibly fitting into the ST concept of the Healthy Adult Mode, the ST focus seemed to be dominated by avoidance goals (thinking and feeling less about the bad stuff) rather than appetitive goals (having more of what is wanted). Whilst the merits of either approach remain an empirical question, I was left wondering what happens when a client is in Healthy Adult Mode: does therapy focus on helping the client to grow further, or is it assumed that the client will do this for themselves now that they are a healthy adult and no longer in need of a therapeutic parent figure?
6.9.4 Final Thoughts

I could relate to many aspects of the ST formulation and treatment plan – recognising evident parallels with my own (ACT-based) formulation of Molly. However, what struck me most about the ST formulation was that there seemed to be a lack of obvious or necessary connection to the concept of schemas (either in the form of EMS or Schema Modes).

The question I was ultimately left with was: In order to be effective, does schema therapy really need schemas at all?

Kerry Beckley

6.10 Author Response

The reviewer suggests there is a lack of evidence for theorised mechanisms of Schema Therapy. There is evidence for components of Schema Therapy, in terms of schemas and modes, but it was not possible to include a thorough review within the confines of a formulation chapter. It is accepted that there are methodological weaknesses in the available research but, overall, this does not detract from the positive body of evidence which is accumulating for Schema Therapy.

The reviewer suggests that the concepts of schemas and modes are ‘infantilising’. It is not my clinical experience that either clients or professionals experience them this way, and the concepts provide a framework for developing a narrative that is often underdeveloped in clients with ‘toxic’ and traumatic early attachment experiences. Schemas and modes are in no way ‘pseudo diagnostic’: modes in particular are terms that are developed in collaboration with the client to ensure personal resonance – to represent these as distinct categories would be to misuse the model.

The reviewer appears to be suggesting that Schema Therapy considers the presence of schemas as evidence of personality disorder. Schemas are considered to be trait-like constructs that develop from unmet needs, and which help us to consider the function of peoples’ actions. Development of schemas is not considered to be ‘disorder’-specific: such consideration would detract from the goal of reducing an ‘us and them’ distinction from individuals who already feel isolated or different from others. A schema therapist does not formulate from the results of a psychometric tool in isolation, and the suggestion that this is the case indicates a misunderstanding on the part of the reviewer. The reviewer also appears to have confused the concepts of schema and core belief in suggesting that there is no evidence linking schemas with distress; schemas have an inherent emotional component, which is activated alongside the cognitive, physical, and visual elements.

The model confusion alluded to in schemas and modes is a valid criticism and therapists less familiar with the model can sometimes underestimate the importance
of the thematic underpinnings of a person’s mode state, which results in the techniques having less clarity in application. However, there is no mythical stage where schemas are ‘set’ just as there is no mythical stage when behavioural patterns become ingrained. Like other therapies, Schema Therapy aims to increase clients’ insight into their difficulties and applies a particular framework to guide movement towards therapeutic change: using the therapy relationship to develop a relational template that enables clients to interact with others in ways which results in their core needs being met. How we as therapists achieve this will forever be a source of debate, and the research repeatedly tells us that the key to achieving it is the quality of the therapeutic relationship. If formulations using apparently disparate psychological models can agree on the primary issues of the client, perhaps the differences in approach are somewhat irrelevant in delivering psychological therapy?

References


