arnoud arntz and gitta jacob

schema therapy in practice

an introductory guide to the schema mode approach

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An Introductory Guide to the Schema Mode Approach

ARNOUD ARNTZ, PHD*
Department of Clinical Psychological Science,
Maastricht University,
The Netherlands & Netherlands Institute for Advanced
Study in the Humanities and Social Sciences,
Wassenaar, The Netherlands

GITTA JACOB, PHD
Department of Clinical Psychology and Psychotherapy,
Freiburg University, Germany

*The order of authors is based on alphabetical order

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About the Authors

Arnoud Arntz is Professor of Clinical Psychology and Experimental Psychopathology at Maastricht University, the Netherlands. He is Scientific Director of the University's Research Center of Experimental Psychopathology. He studies psychological theories and therapies for anxiety and personality disorders, and is the principal investigator for a series of multicenter trials investigating the effectiveness of schema therapy for various personality disorders. He also practices CBT and schema therapy.

Gitta Jacob is a Clinical Psychologist, Cognitive and Schema Therapist in the Department of Clinical Psychology and Psychotherapy, University of Freiburg, Germany. She is a founding board member of the International Society for Schema Therapy, and a past Chair of the Working Group on Borderline Personality Disorders at the Department of Psychiatry and Psychotherapy, University Hospital Freiburg.

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Introduction

Schema therapy is increasingly attracting the attention of therapists and consumers. This is partly based on the good effects reported by various studies, and partly on its appealing basis in the idea that children require fundamental needs to be met in order to develop in a psychologically healthy way. The integration of insights, methods, and techniques derived from a range of schools, including attachment theory, cognitive behavior therapy, and experiential therapies into a comprehensive model formulated in terms of the most prominent current psychological paradigm, the cognitive model, also plays a role. The promise of schema therapy that it can deal with psychological problems largely ignored by mainstream cognitive behavior therapy, such as recurrent problems in intimate relationships and the processing of troublesome memories and patterns from childhood, is attractive. Finally, the finding that schema therapy contributes to real recovery, defined not only by a reduction of symptoms, but by the creation of a life that is satisfying and of high quality, is undoubtedly appealing.

In teaching the model, methods, and techniques, we felt that a book presenting the practical basics of schema therapy for those that want to learn it as a generic method, and not in a specialized form for one disorder, was missing. We therefore decided to write such a book. This book does not compete with other publications on schema therapy, as it doesn't focus on theory or on a specific disorder. It aims to present the basics of the schema-therapy model based on the relatively new schema mode concept. It is basically an extension of our work with schema modes in almost all personality disorders. As we felt that the mode approach could also have application in some axis-I problems, and in milder personality issues, we decided to present the model, methods, and techniques in a generic way, and to use case examples of various disorders and problems.

The book is divided into two parts. The first deals with case conceptualization and consists of three chapters: Chapter 1, "Basics," summarizes the original schema approach by describing schemas and schema coping through the use of case examples; Chapter 2, "The Mode Concept," describes the schema mode concept in general terms, then goes on to provide descriptions of the specific mode models for various personality disorders that have been developed so far; finally, Chapter 3, "Communicating the Mode Concept to the Patient," explains how an individual mode model can be introduced in therapy.

The second part deals with treatment, in six chapters. Each chapter is devoted to one group of modes and is subdivided into sections on cognitive, emotional, and behavioral interventions and the therapeutic relationship. Chapter 4, "Treatment Overview," summarizes the central treatment goals and strategies of schema therapy based on the mode concept. Chapter 5, "Overcoming Coping Modes," describes how to deal with coping modes. It covers avoiding (detached protector, avoiding protector, etc.), surrender, and overcompensating coping modes (self-aggrandizer, bully & attack, etc.). Chapter 6, "Treating Vulnerable-child Modes," describes how to deal with vulnerable-child modes. It contains a long section on imagery rescripting and discusses the caring part of the therapeutic relationship in depth. Chapter 7, "Treating Angry and Impulsive Child Modes," describes how to deal with angry, enraged, impulsive, undisciplined, and obstinate child modes. Chapter 8, "Treating Dysfunctional-parent Modes," describes how to deal with both demanding- and punitive-parent modes. It contains a long section on chair dialogues as a therapeutic technique. Chapter 9, "Strengthening the Healthy-adult Mode," summarizes how the healthy adult mode is explicitly and implicitly developed in schema therapy. It also addresses how the treatment should develop when completion is near, and how to relate with the patient after formal completion of treatment.

I

CASE CONCEPTUALIZATION

1

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.

Schema Therapy in Practice: An Introductory Guide to the Schema Mode Approach, First Edition. Arnoud Arntz and Gitta Jacob.

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.

(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 helpless 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.