The Schema Therapy Clinician's Guide

A Complete Resource for Building and Delivering Individual, Group and Integrated Schema Mode Treatment Programs

Joan M. Farrell • Neele Reiss • Ida A. Shaw

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CONTENTS

List of Tables

List of Illustrations

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List of Figures and Tables

Figures

Tables

About the Authors

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Foreword

I am very pleased to have been invited to write the foreword for this groundbreaking resource, which will allow clinicians to integrate Individual and Group Schema Therapy (GST) sessions into complete treatment programs that can be delivered over a range of patient populations, treatment lengths, and levels of care.

Since I first heard about the extremely positive results of the authors' randomized controlled trial of GST for patients with borderline personality disorder (BPD) in 2008, I have been very excited about the potential of the group model to make Schema Therapy more available and affordable for patients. Given the worsening climate for mental health reimbursement in this era of managed care in the United States and elsewhere in the world, Group Schema Therapy has the potential to deliver the powerful treatment strategies of the schema approach in a more cost-effective manner than has been possible with individual schema therapy – with equivalent or perhaps superior results. I am especially excited about the large-scale clinical trial that is under way at 14 sites in six different countries. Arnoud Arntz and Joan Farrell serve as the co-principal investigators of the study, testing the efficacy and cost-effectiveness of the Group Schema Therapy model for BPD patients combined with two different numbers of individual sessions.

This book, with the collaboration of Neele Reiss, the psychologist and schema therapist who pioneered GST in Germany, extends the integrated Individual and Group Schema Therapy program for use with a wide range of patient groups – personality disorder, complex trauma, chronic difficulties, those who have failed in other

treatments, and those who need a higher level of care. It includes the novel concept of giving patients a “bank account” of individual ST sessions to draw on, as they need to; this concept was developed for the BPD multisite trial. Since the publication of the first book on GST (Farrell & Shaw, 2012), there have been many initiatives internationally to apply the GST model to other diagnostic groups of patients. Like individual ST, GST is trans-diagnostic – in the sense that the focus of interventions is the mode profile of the patient rather than specific symptoms. Thus, GST, like ST, should be effective for disorders other than BPD. Of course, any application needs empirical validation and I am happy to say that preliminary findings are promising. This integrated program has been tested in inpatient and day hospital settings for BPD (Reiss *et al.*, 2013a) and mixed Cluster B and C disorders (Muste, 2012; Fuhrhans, 2012). Its use in forensic settings is being evaluated in the UK. A randomized controlled trial comparing ST to cognitive–behavioral therapy (CBT) for avoidant PD and social phobia and an experimental case series for dissociative disorders are under way in the Netherlands.

The integration of Group and Individual Schema Therapy presented here feels entirely consistent with my own individual model, in terms of the conceptual model, therapeutic alliance, and treatment interventions. The GST model encourages group members to become like a healthy family in which they can “re-family” each other, under the watchful guidance of two highly skilled therapist-parents. The sense of belonging and acceptance provided by this group analogue of a loving family seems to catalyze both the limited reparenting and emotion-focused components of ST. Furthermore, by utilizing two co-therapists for each group, GST has found a way to free up one therapist to move fluidly around the group, often

working with one or two members at a time, creating novel experiential exercises to bring about change. At the same time, the second therapist serves as the “stable base” for the rest of the group, maintains an ongoing emotional connection with each member, monitors the reactions of all members, explains what is happening to educate them about what is taking place, and intervenes to shift the direction of the group to focus on the needs of other group members. I am also impressed that GST goes well beyond the traditional CBT/DBT (dialectical behavioral therapy) group format, in which members are taught skills in a seminar-like setting; and beyond non-CBT groups, in which the therapist does individual work with one member while the rest of the group primarily watches. In GST, the techniques used in Individual Schema Therapy, like imagery change work and mode role-plays, have been adapted to engage all of the members in unique exercises that make use of the power of group interaction and support. These group therapeutic factors, combined with the broad range of integrative techniques that are already part of ST, may account for the large treatment effects in the controlled outcome study I mentioned earlier, as well as in preliminary data from other ongoing studies of GST.

The authors describe a systematic approach to ST treatment, while retaining the flexibility that I have always valued so highly in developing Individual Schema Therapy. The treatment suggestions are specific and well organized, while avoiding the temptation to write a therapeutic “cookbook” for therapists to follow in a rote manner. The authors have preserved the core elements of ST by developing “limited reparenting” intervention strategies for each mode that arises, seizing “experiential moments” to do emotion-focused work that brings about change at a deep level. Like individual ST, their group model blends experiential, cognitive, interpersonal, and behavioral work.

The program presented here divides ST interventions into four main components: Schema Therapy Education, Mode Awareness, Mode Management, and Experiential Mode Work. There are sessions of each component that target the main schema modes one at a time. The individual and group sessions are coordinated by mode. The individual ST sessions give therapists the option of a cognitive, experiential, or behavioral pattern-breaking intervention. The authors provide specific therapist script examples that allow access for the beginner using ST, yet have the essential flexibility of ST so that they can be adapted to meet an individual patient's mode and need. The combination of structure and flexibility in this manual make it accessible to practitioners at all levels of experience with ST. The book is written at a level that should appeal to a very broad range of mental health professionals, including psychologists, social workers, psychiatrists, counselors, and psychiatric nurses, as well as interns and residents.

The experience that the authors have gained over 30 years of training therapists throughout the world, and of leading GST groups with a broad range of clinical populations, is evident throughout the volume. This book is the first published treatment manual for integrating Individual and Group Schema Therapy, and succeeds in providing the most essential information that clinicians will need in order to develop and implement such programs. The program sessions can be delivered in intensive form for higher levels of care, such as inpatient and day therapy, or spread over a year of outpatient treatment. The program could begin with more sessions per week, then taper in intensity and be moved to outpatient care. The user-friendly format of the book includes patient examples, descriptions of group and individual sessions, and examples of therapist scripts to explain core ST concepts in language easily understood by patients, along with patient handouts, exercises, and

assignments. This material is presented in the manual itself as well as being available in downloadable form on the Wiley website for use with patients.

On a more personal level, I had the opportunity to experience GST first hand as a participant at an advanced training workshop that I invited Joan and Ida with Neele to teach for the senior schema therapists at our New York institute. I am even more excited about the potential of ST in a group after this experience, and would love to conduct an ST group like this myself once I have learned the necessary skills. Joan Farrell is an outstanding schema therapist who serves as the "stable base," emotional center, and "educator" for the group as a whole – a role I can imagine myself learning to fill, given enough time and experience. What truly amazed me – perhaps because her style is so different from mine and Joan's – was the remarkable group work of Ida Shaw. It is hard to convey the level of originality, creativity, and spontaneity she brings to the group experience. She is able to blend elements of gestalt, psychodrama, role-playing, and her own infectious style of play into an approach that perfectly fits the intensive demands of schema mode work, cajoling patients to change in profound ways. The group exercises in this manual will allow schema therapists to try out some of her unique work. Neele Reiss adds the perspective of the "next generation" of schema therapists who are intent upon practicing and empirically validating ST. She collaborated on inpatient studies of the integrated model for BPD patients (Reiss *et al.*, 2013a) and her current work applies ST interventions to problems like test phobia and eating disorders.

I highly recommend this outstanding manual to all mental health professionals working with more complex, chronic, and hard-to-treat patient populations – especially those who are looking for an evidence-based, cost-effective alternative

to existing therapies. This book is essential reading for professionals interested in schema therapy, BPD and other personality disorders, group therapy, and new approaches to expanding CBT.

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March 2014

Acknowledgments

This book is the culmination of our collaboration with Neele Reiss that began in 2008 when we discovered at the International Society of Schema Therapy Conference in Portugal that someone else in the world was doing Schema Therapy in groups. We have had hours of discussion, fun, and ice cream since then and the development of an important friendship which we treasure. We thank Arnoud Arntz for his mentorship, personal support, and friendship; Jeff Young for his thought-provoking discussions, support, and encouragement and Wendy Behary for commiserating about the arduous task of writing and for humor at needed moments.

The therapists who trained with us made important contributions to this treatment manual as teaching them forced us to make explicit and clear the way we practice Group Schema Therapy. Most of all we thank our patients, who taught us what we needed to understand about their needs and struggles and what worked to help them.

Special thanks from Joan to Elke and Siegbert Reiss for their warm hospitality, lovely meals, and fine wine during a heavy writing period as well as German history lessons and sightseeing during much needed breaks.

Joan Farrell and Ida Shaw

Writing this book with my close friends Joan and Ida has been a wonderful journey with many new discoveries. I want to thank you for the collaboration and the warm friendship over the past years.

I would also like to thank Friederike Vogel, who has been a very supportive colleague ever since we started working

together and has become a dear friend to me. Furthermore I would like to thank all my patients – without them I would never have learned to practice Schema Therapy and Group Schema Therapy.

Last but not least, I would like to thank my family, especially my father Siegbert and my mother Elke, and my best friend Steffi – for your patience, your advice, for grounding me whenever needed, and for your unconditional support at all times. I know I can count on you.

Neele Reiss

1
Introduction

This manual presents an integrated Individual and Group Schema Therapy Program that is transdiagnostic, designed to be implemented in a variety of treatment settings and in programs of varied length. It is written for psychotherapists in a practical manner with a clinical focus. Sample therapist scripts, detailed session instructions, and handouts for each individual and group session are provided.

1.1 Background

Schema Therapy (ST), developed originally for individual psychotherapy by Young (1990; Young, Klosko, & Weishaar, 2003), is an approach to the treatment of a wide variety of psychological disorders that integrates cognitive, experiential, or emotion-focused and behavioral pattern-breaking interventions. It is a comprehensive model that strategically integrates aspects of other approaches but remains unique. A group version of ST was developed (Farrell & Shaw, 2012; Reiss & Vogel, 2010; Muste, Weertman, & Claassen, 2009). The effectiveness of individual (IST) and group (GST) therapy for borderline personality disorder (BPD) has been validated empirically (Giesen-Bloo *et al.*, 2006; Farrell, Shaw, & Webber, 2009; Reiss, Lieb, Arntz, Shaw, & Farrell, 2013a; Nadort *et al.*, 2009). The model of ST is transdiagnostic. The use of ST for avoidant personality disorder (PD), social anxiety, eating disorders, post-traumatic stress disorder, narcissism, antisocial PD, substance abuse, and psychopathy is being explored and evaluated internationally. It is an approach

that is rated positively by both patients and therapists (Spinhoven, Giesen-Bloo, van Dyck, Kooiman, & Arntz, 2007). In addition, ST has growing evidence of its cost-effectiveness for the individual modality (IST) (Giesen-Bloo *et al.*, 2006; Nadort *et al.*, 2009). However, the limited availability of specialized individual psychotherapies, including ST, in the current healthcare economy has prevented more wide-scale use of IST in clinical settings. An integrated program combining multiple GST sessions with a limited number of IST sessions in a structured program has been evaluated, with promising results (Muste, Weertman, & Claassen, 2009; Reiss *et al.*, 2013a). Combining more frequent group ST sessions with strategically planned individual sessions has the potential for making this promising treatment more widely available in a larger number of settings.

The concept of an integrated and structured program was originally developed for use with severe patients in hospital settings (Reiss *et al.*, 2013a), but it can be implemented across a wide range of patient populations, treatment settings, and treatment lengths. One patient population for whom it is ideal are those with personality disorders or PD features, those with chronic or complex psychological problems, those with multiple trauma histories, and those for whom other treatment approaches have failed. In general, these are patients who are treated at the higher levels of care and whose life potential is tragically not realized in the quality of their lives. An advantage of Schema Therapy is that it approaches treatment by targeting maladaptive schema modes rather than specific symptoms or disorders, thus transcending psychiatric diagnoses and impending changes in diagnostic classification. This program can be implemented in inpatient, day therapy, and intensive outpatient settings, as well as in general outpatient treatment with varying

session frequency. A program of intensive sessions as the beginning of outpatient treatment may act to “jump-start” the treatment of patients with entrenched maladaptive coping strategies that produce the severe and sometimes life-threatening symptoms of disorders like BPD. It is possible to use all the handouts provided throughout this book within the context of individual ST treatment or selectively within other psychotherapy models. For example, the experiential interventions can augment cognitive therapy, filling a gap in that approach to treating patients with personality disorders and complex trauma.

The program of the manual is theoretically consistent with individual ST (Young *et al.*, 2003) and group ST (Farrell & Shaw, 2012). Like most approaches to psychotherapy that go beyond skills training, ST requires specialized training to meet adherence and competence standards. This manual was designed to make IST, GST, and their integrated combination accessible for a wide range of psychotherapists of multiple theoretical orientations, including those working in intensive settings like inpatient and day therapy programs. The manual provides a detailed step-by-step guide for an ST fundamentals program that integrates IST and GST sessions. The program includes the core components of ST: limited reparenting, education about the ST model, mode awareness, mode management and cognitive, experiential, and behavioral pattern-breaking change work. It can be used across diagnostic groups. There are 12 individual sessions and 42 group sessions. Each session is described in terms of goals, therapist interventions, tips on management, sample session scripts for therapists to adapt, and corresponding information handouts, ST exercises, and therapy assignments. The individual sessions are designed to be complementary to the group work and the schema mode being focused on, while still allowing individual needs to be

met. How to balance individual and group focus is discussed throughout. This level of detail will allow therapists new to Schema Therapy to conduct sessions with confidence and to coordinate group work effectively with individual work. It will also allow more experienced individual schema therapists to begin leading ST groups effectively. The program is not a rigid protocol, but rather a framework combining flexibility with standardization. The structured yet flexible format serves a number of purposes: the manual can be used as a detailed plan for implementing a structured, integrated program of individual and group ST in higher levels of care settings with multiple sessions per week; as a research protocol for psychotherapy outcome studies; or clinicians can select individual or group sessions, or the combination, to work on specific schema modes. Therapists can choose whether to implement the program as a whole, or to select individual sessions, group sessions, or a combination of both to suit their group and its needs.

1.2 The Chapters

Chapter 2 presents the basic concepts of the ST model originally developed for individuals by Young (Young *et al.*, 2003) and the adaptation for groups developed by Farrell and Shaw (2012). The goals of ST, the therapist approach of limited reparenting, and the core components of the model are described in this chapter. The approach of the integrated ST program to combining individual and group sessions is discussed. The general course and stages of the treatment program are outlined here. Chapter 3 describes some of the essentials of the treatment program: the patients, with inclusion and exclusion factors; the therapists; the milieu – both the physical setting and the multidisciplinary treatment team; the length of sessions

and treatment; and the possible schedules and format for delivering the program in different settings. Chapter 4 presents the group sessions by component, with sample therapist scripts and the patient materials – handouts, group exercises, and session assignments. Chapter 5 presents the 12 individual sessions – with specific content, sample scripts, and handouts. Chapter 6 describes the ST training and supervision recommended for therapists. The research that has been conducted is summarized, with a brief description of the investigations that are in progress at the time of writing.

This book is unique in the ST literature as its goal is to provide an implementable program in its entirety. It is not focused on a particular disorder. It is not limited to one of the modalities of treatment delivery; it covers both individual and group ST. The reader is referred to the ST volumes in the References for theory and focus on specific disorders.

2
The Basics of Schema Therapy

2.1 The Theoretical Model

The model presented in this manual is consistent with the theory, components of treatment, and goals presented by Young, Klosko, and Weishaar (2003). The Schema Therapy (ST) model is summarized here and the reader is referred to that volume for additional elaboration of the individual ST model and its application. ST grew out of efforts by Young *et al*. (2003) to treat patients with personality disorders more effectively, and also those who either did not respond to traditional cognitive therapy or relapsed. ST is based upon a unifying theory and a structured and systematic approach. Because ST is an integrative treatment, there is overlap with other psychotherapy models such as cognitive and psychodynamic psychotherapy, object relations theory, and Gestalt psychotherapy, but total overlap with no other model.

Figure 2.1 summarizes the model for the etiology of psychopathology posited by ST. When the normal, healthy developmental needs of childhood are not met, maladaptive schemas develop. Maladaptive schemas are psychological constructs that include beliefs we have about ourselves, the world, and other people, which result from interactions of unmet core childhood needs, innate temperament, and early environment. ST views this interaction in terms of a plasticity or differential susceptibility model. Schemas are comprised of memories, bodily sensations, emotions, and cognitions that originate in childhood and are elaborated through a person's lifetime. These schemas often have an adaptive role in childhood (e.g., in terms of survival in an abusive situation – it engenders more hope for children if they believe they are defective as opposed to the adult being defective). By adulthood, maladaptive schemas are inaccurate, dysfunctional, and limiting, although strongly held and frequently not in the person's conscious awareness. Young (1990; Young *et al.*, 2003) identified 18 early maladaptive schemas (EMS) in patients with personality disorders (Table 2.1). The schemas are defined individually in the patient materials for the ST Education group (ST-Education Sessions 1–5).

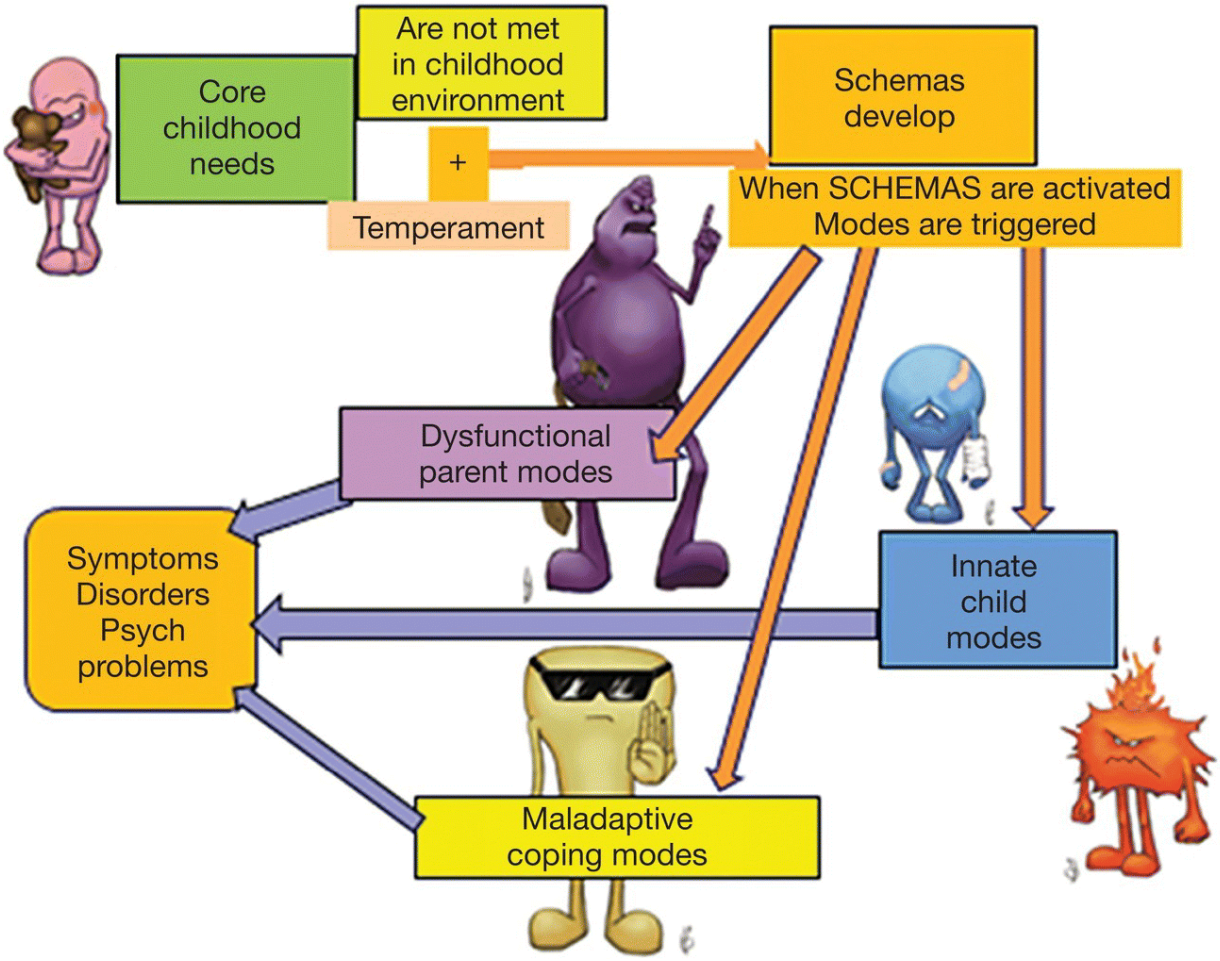

Figure 2.1 Schema Therapy: Etiology of psychological disorders.

Table 2.1 Schemas organized by content area

Disconnection and rejection	***Impaired autonomy and performance***
Mistrust/Abuse Emotional Deprivation Defectiveness/Shame Social Isolation/Alienation Emotional Inhibition	Dependence/Incompetence Vulnerability to Harm/Illness Enmeshment/Undeveloped Self Abandonment/Instability Subjugation Failure
Impaired limits	*Exaggerated expectations*
Entitlement Insufficient Self-Control	Self-Sacrifice Unrelenting Standards
Other	
Negativity/Pessimism Punitiveness	Approval-Seeking/Recognition-Seeking

When maladaptive schemas are activated, intense states occur, described in ST as “schema modes.” A schema mode is defined as the current emotional, cognitive, and behavioral state that a person is in. Dysfunctional modes occur most frequently

when multiple maladaptive schemas are activated. Four basic categories of modes are defined (Table 2.2).

Table 2.2 Basic schema modes

Innate Child Modes	Vulnerable Child Angry/Impulsive Child	Innate responses to unmet needs
Maladaptive Coping Modes	Avoidant Protector OvercompensatorCompliant Surrenderer	Overused survival responses to trauma or unmet needs – flight, fight, and freeze
Dysfunctional Parent Modes	Punitive Parent Demanding Parent	Selective internalization of negative aspects of early others
Healthy Modes	Happy Child Healthy Adult	Underdeveloped

Primary or innate child modes (Vulnerable Child, Angry Child, Impulsive Child) are said to develop when basic emotional needs in childhood (such as safety, nurturance, or autonomy) are not adequately met. These “child modes” are defined by intense feelings such as fear, helplessness, or rage, and involve the innate reactions a child has. Dysfunctional Parent Modes (Punitive Parent or Demanding Parent) comprise the second category of modes. Dysfunctional Parent Modes reflect the selective internalization of negative aspects of attachment figures (e.g., parents, teachers, peers, etc.) during childhood and adolescence. Maladaptive Coping Modes, a third category of mode, are defined by an overuse of unhealthy coping styles (fight – overcompensation; flight – avoidance; or freeze – surrender). All have the goal of protecting the person from experiencing pain, anxiety, or fear. These Maladaptive Coping Modes operate outside of conscious awareness and a goal of ST is that patients become aware of their coping styles and learn healthier, more adaptive coping responses. Maladaptive Coping Modes incorporate the concept of defense mechanisms, a concept previously missing in cognitive therapy, and allow for a better understanding of personality disorders by clinicians and patients. The overcompensating coping style contains modes in which a person acts in opposition to the schema or schemas that are triggered. One example is the Bully-Attack Mode in which the person experiencing the pain resulting from a schema retaliates by causing pain. The avoidant coping style involves physical, psychological, and social withdrawal and avoidance. Avoidant Modes include the Detached Protector, a mode that ranges from a person being “spacey,” or briefly losing focus in an interaction, to severe dissociation. This mode is very commonly present when patients enter therapy as it operates to protect the Vulnerable Child Mode from overwhelming fear or painful feelings. Surrender is the third coping style and it represents giving in or giving up to the schema present. For example, if the triggering schema is defectiveness, a surrender response would be to accept that you are defective and behave accordingly: never taking on challenges, working not to be exposed as incompetent.

In a fourth category, Healthy and Functional Modes, the Healthy Adult Mode and Happy Child Mode are found. The Healthy Adult Mode includes functional thoughts and behaviors, and the skills needed to function in adult life. The Happy Child Mode is a resource for playful and enjoyable activities, especially in social networks. Many patients were neither allowed nor encouraged to play, thus missing opportunities to explore their likes and dislikes and take part in our earliest social interactions with

peers. The healthy modes tend to be severely underdeveloped in patients with personality disorders or features.

Modes are often triggered by events that patients experience as highly emotional. Modes can switch rapidly in patients suffering from severe personality disorders, resulting in the sudden changes in behavior or seemingly disproportionate reactions that are one source of patients' interpersonal difficulties and emotional and behavioral instability. Modes can also stay rigidly entrenched, as is the case with many avoidant patients. Common negative coping responses – aggression, hostility, manipulation, exploitation, dominance, recognition-seeking, stimulation-seeking, impulsivity, substance abuse, compliance, dependence, excessive self-reliance, compulsivity, inhibition, psychological withdrawal, social isolation, and situational and emotional avoidance – can be understood in mode terms.

Symptoms of personality disorder can be described and understood in terms of the operation of modes. One example is the ST conceptualization of borderline personality disorder (BPD). Abandonment fears describe the emotional state of the Vulnerable Child Mode. Intense anger, at times accompanied by uncontrolled expressions of anger, occurs in the Angry Child and Impulsive Child Modes. The Impulsive Child Mode fuels action that is potentially damaging as well as being one source of self-injurious behavior. The Dysfunctional Parent Modes are another source of self-injurious behavior, to fulfill their dictate that the child deserves punishment or is a failure. The parent modes can also be a source of suicide attempts as they remove all hope and their judgments condemn the patient to misery and feelings of worthlessness. The Detached Protector Coping Mode can be a cause of self-injurious behavior, particularly cutting or burning the skin in order to feel something. The Detached Protector Mode explains the experience of emptiness, which can be intolerable and can lead to suicide attempts. If you are detached from your feelings, a central part of who you are, your identity will not be stable. Mode-flipping accounts for some of the emotional reactivity seen in BPD patients and consequently their unstable relationships.

Other personality disorders and psychological problems can just as easily be described in mode terms, providing user-friendly, understandable language for patients and the foci for psychotherapeutic intervention for therapists. Mode language focuses more on the role of learning and less on psychopathology, giving patients hope regarding change.

2.2 Goals and Stages of Schema Therapy

Young *et al*. (2003) summarizes the primary goals of treatment as helping patients change dysfunctional life patterns and get their core needs met in an adaptive manner outside of therapy, *by changing schemas and modes*. The goals of ST reach beyond teaching behavioral skills to include the fundamental work of personality change. This change is conceptualized as involving decreasing the intensity of maladaptive schemas that trigger under- or over-modulated emotion and action states referred to as modes. The triggering of these intense states is seen as interfering with patients' use of adaptive coping or interpersonal skills that would allow them to realize their potential and improve their quality of life. In terms of each type of mode, the goals can be elaborated as:

To develop the Healthy Adult Mode so that the patient is able to:

1. Care for the Vulnerable Child Mode. Healthy adult competence is accessible when fear, sadness, or loneliness, which reflect unmet childhood needs, is triggered.
2. Reassure and replace the Maladaptive Coping Modes. For example, be able to experience emotions when they arise, connect with others, and express your needs. Coping choices that meet the person's need and the reality of the adult situation he/she is in are made, rather than defaulting to Maladaptive Coping Modes like avoidance.
3. Replace the behavior of the Angry/Impulsive Child Mode with appropriate and effective ways to express emotions and needs; e.g., the ability to express needs in an assertive adult manner and anger in a healthy way.
4. Overthrow and banish the Punitive Parent. Get rid of the harsh internalized critic, replacing it with the ability to: motivate oneself in a healthy positive manner; accept one's mistakes and, when needed, make retribution for them. Moderate the Demanding Parent Mode to have realistic expectations and standards.

We add a fifth goal:

5. Free the Happy Child Mode so that the patient can explore the environment to learn about what gives him/her joy in life and can play.

ST approaches these goals in stages. The **stages** and the **goals** of each stage can be summarized as:

1. Bonding and emotional regulation:
   - healing the Vulnerable Child;
   - bypassing the Maladaptive Coping Modes;
   - affect regulation and coping skills.
2. Schema mode change:
   - combating the Punitive Parent and Demanding Parent Modes;
   - rechanneling the Angry and Impulsive Child;
   - setting limits;
   - handling crises.
3. Autonomy:
   - individuation: following natural inclinations;
   - developing healthy relationships;
   - gradual termination with the option of contact.

2.3 Limited Reparenting

Limited reparenting is both a therapist style and an active ingredient or component of mode-change work. Limited reparenting is defined as: acting as a good parent would in meeting child mode needs within the bounds of an appropriate therapy

relationship. This means providing protection, validation, and comfort for the Vulnerable Child Mode; the opportunity to vent and be heard for the Angry Child; and empathic confrontation and limit setting for the Impulsive Child Mode. Limited reparenting is one of the core components of ST and a hypothesized active ingredient. Limited reparenting is often referred to as the “heart of ST.”

The behaviors of the schema therapist can be summed up as “doing what a good parent would.” Early in treatment, strong parenting is needed as patients are frequently in child modes and have an underdeveloped Healthy Adult Mode. Later on, there is more Healthy Adult presence and the therapist’s role changes to being the “parent” of adolescents and then eventually of adults. In this later phase, patients still need the therapist to maintain connection, but are able to do some parenting of themselves and each other. The language, sophistication, and use of specific ST techniques must be adapted to the developmental level, comorbid disorders, and psychological health of the group members (i.e., some techniques and terminology that may be helpful with BPD patients may not be acceptable to narcissistic personality disorder patients, etc.). When working with the Vulnerable Child Mode, we sound like parents talking to a young, frightened child. When confronted with Maladaptive Coping Modes we can become almost as firm as a drill sergeant (while at the same time not losing touch with letting the patient know that we empathize with the feelings and needs underneath the mode).

The goal of limited reparenting is to establish an active, supportive, and genuine relationship with the patient that provides a safe environment for the patient to be vulnerable and to express emotions and needs. The therapist’s provision of limited reparenting within the psychotherapy relationship allows the patient to fill in critical early gaps in emotional learning via secure attachment and accurate mirroring that lead to experiencing feeling valued and worthy, often for the first time. Initially, the therapist tries to compensate for the deficits in the patient’s emotional needs being met within the limits of appropriate professional boundaries. Some of the unmet childhood needs include: safety, consistency, validation, appropriate boundaries, and healthy limits. Over time, the experience of the therapy relationship fosters patients learning to care for their own needs in an effective manner and eventually to attain autonomy and healthy interpersonal functioning. This approach to needs is in sharp contrast to most other models, which focus too early on patients meeting their own needs. ST assesses the strength of patients’ Healthy Adult Mode and attempts to fill gaps in early emotional learning about needs through an initial phase in which therapists meet needs directly, providing new positive experiences directly. The new experiences, interactions, and implicit attitudes that make up the process of meeting core emotional needs become the building blocks for the Healthy Adult Mode. Table 2.3 describes the relationship among the mode a patient is in, the unmet childhood need involved, and the therapist intervention required.

Table 2.3 Suggested therapist interventions in relationship to patient modes and needs

Schema mode	***Unmet childhood needs***	***Therapist intervention Limited reparenting***
Vulnerable Child Experiences intense feelings of sadness, loneliness, anxiety. Emotional pain and fear can become overwhelming and lead to flips into the Maladaptive Coping Modes.	Secure attachment (includes safety, predictability, stable base, love, nurturance, attention, acceptance, praise, empathy, guidance, protection, validation).	Meet the listed needs, comfort, soothe, reassure, wrap in blanket, connect with vulnerable child (VC) in a concrete way to match developmental level, listen, reassure fears, soft tones.
Angry Child Vents anger directly in response to perceived unmet core needs or unfair treatment. Can take the form of a young child's tantrum.	Guidance, validation of feelings and needs, realistic limits and self-control. Freedom to express, validation of needs and emotions.	Listen, emotional expression, support venting, guide them into safe anger expression (e.g., tug-of-war), set limits for safety or to prevent negative consequences. Help them identify unmet need they are responding to, understand that they may have difficulty thinking while very angry.
Impulsive/Undisciplined Child Impulsively acts based on immediate desires for pleasure, without regard to limits or others' needs (not related to core needs).	Realistic limits and self-control, validation of feelings and needs, guidance.	Set gentle yet firm limits, guide, teach healthy release exercises. Help them identify the need that is present.
Happy Child – underdeveloped Feels loved, connected, content, satisfied.	Spontaneity and play. Nurturance, attention, validation, acceptance, encouragement to explore and play.	Take pleasure in them and their playfulness and show this visually, smiles, laughter, invite them to play, play with them.
Punitive Parent Restricts, criticizes, and punishes self and others. Harsh, rejecting, all or none in judgments.	The Dysfunctional Parent Modes suppress and reject the needs of the child. This can apply to any need – particularly love, nurturance, praise, acceptance, guidance, validation, emotional expression.	Stop the Punitive Parent Mode (PPM) message, set limits on and eventually banish this mode. Support and connect with the VC needs.