Schema Therapy

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Synonyms
\Schema-focused therapy

Definition

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Schema therapy (ST) is an integrative psychotherapy model which grew out of Beck’s (1976) cognitive therapy, gradually developing into a unique integrative treatment for a spectrum of long-standing emotional/relational difficulties, including personality disorders. Beginning in the 1980s, Young (e.g., 1990) noted that cognitive therapy with nonresponders or relapse-prone clients required shifting the focus from surface-level cognitions to deeper constructs — namely, schemas — which gave the approach its name.

Schemas are enduring foundational mental structures, which go beyond being purely cognitive features of the mind to encompass emotions, bodily sensations, images, and memories. Young (1990) and Young et al. (2003) proposed a taxonomy of early maladaptive schemas, thought to emerge when core emotional needs go unmet or are met inappropriately, usually by a child’s caregivers. (Though the formation of schemas is driven to a large degree by unmet needs, other factors such as temperamental vulnerability and cultural norms play major roles as well.) These needs (e.g., for safety, security, validation, autonomy, spontaneity, and realistic limits) are seen as universal. In infancy and childhood, meeting these needs falls to the child’s caregivers and is considered necessary for a child to develop into psychological health as an adult.

ST argues that enduring or recurrent distress often stems from present-day activation of early maladaptive schemas. At times, problems directly involve the distress felt when the schemas are activated. Quite often, however, they result from the characteristic behaviors enacted in respond to (or coping with) schemas — behaviors referred to as “coping styles” — typically ones involving overcompensation, avoidance, or surrender (i.e., fight, flight, or freeze).

Starting in the mid-1990s, Young and colleagues (e.g., McGinn and Young 1996; Rafaeli et al. 2010) began recognizing the necessity of revising ST to move beyond a predominant focus on universal needs, pervasive schemas,
and characteristic coping styles. These constructs are all *trait*-like and therefore leave, unexplained, much of the phenomenology and symptomatology of the clients for whom ST was developed in the first place – individuals who manifest quick and often intense fluctuation among various self-states or moods. This led to the development of the *mode* concept. A mode reflects the predominant schema and/or coping reaction active for an individual at a particular moment in time. Modes are transient, and at any given moment, a person is thought to be predominantly in one mode. Though most individuals inhabit various modes over time, the manner in which they transition from one mode to another – that is, the degree of separation or dissociation between the modes – differs and lies on a spectrum. On the milder end, modes could be like moods; at the most extreme end, a total separation and dissociation could exist between modes, with each entailing a complete and different personality, as is the case in dissociative identity disorder.

Individuals also differ in the specific identity of the modes they tend to inhabit. For example, persons suffering from borderline personality disorder (BPD) tend to experience abrupt transitions and a strong dissociation among a *specific* set of characteristic modes (Lobbestael et al. 2008). While the concepts of modes and of mode work are broad enough to describe any individual, recent efforts have been made to move from an abstract mode model to detailed, concrete, and disorder-specific mode models (cf., Arntz and Jacob 2012).

**The emergence of modes and their taxonomy**

Human beings are born organized with a basic set of loosely interconnected “behavioral states,” specific patterns of psychological and physiological variables that occur together and repeat themselves, often in highly predictable sequences, and that are relatively stable and enduring over time. Discrete behavioral states comprise particular affects, arousal, and energy levels, motor activities, cognitive processing (e.g., abstractness of thought), access to knowledge and autobiographical memory, and a sense of self (Putnam 1989). These states reflect the total pattern of activation in the brain at a particular moment in time. They serve as a clustering of functionally synergistic processes that allow the mind as a whole to form a cohesive state of activity, which maximizes the efficiency and efficacy of the processes needed in a given moment in time to deal with a current situation. Over time and with repeated activation, these basic states cluster together into self subsystems – i.e., modes.

ST posits the existence of four major categories of modes. As a treatment approach, it argues that each category requires a very different clinical response.

**Child Modes** When a child’s emotional needs are met adequately enough, the child (and later the adult) gains access to a *Contented/Happy Child mode*. In it, the person experiences closeness and trust and is able to draw on inner sources of vitality, spontaneity, and curiosity. ST seeks to reconnect clients with their Happy Child mode by removing barriers to these feelings and creating opportunities for such feelings even when no such opportunity existed in childhood.

When a child’s needs do not get adequately met, a *Vulnerable Child (VC) mode* emerges. The VC mode is present for everyone to some degree, but its form and content differ from person to person, depending primarily on the unique profile of met and unmet needs. Though rooted in childhood experiences, the VC mode can often be triggered in an adult’s life by situations that bear varying degrees of similarity to the originating experience (e.g., aversive or ambiguous interpersonal interactions). When these occur, clients essentially re-experience an earlier trauma, typically of a relational kind (Howell 2013). The re-experiencing brings with it concomitant distress (e.g., fear, shame, loneliness). Typically, the client is not aware that the distress is linked to earlier experiences; instead, when in the VC mode, clients simply think and feel as they did as vulnerable or mistreated children and expect others to behave toward them the way people did at that age. In other words, the VC mode essentially embodies, in their purest form, most of the maladaptive schemas (with the exception of those characterized by acting out).
A primary goal of ST is to heal the relational trauma of unmet needs. To do so, ST helps clients make their VC mode present and visible, allow it to receive care (at first from the therapists themselves), and, over time, learn how to internalize and generalize this care. This process, in which therapists identify and partially gratify the unmet needs of the VC, is the central therapeutic stance within ST and is referred to as limited reparenting.

In addition to the Happy and Vulnerable child modes discussed above, early life experiences often give rise to two additional child modes. The first is the Impulsive/Undisciplined Child (IUC) mode, which often results from improper limit setting on the parents’ part. It embodies those schemas characterized by externalizing behavior (e.g., entitlement and insufficient self-control schemas). The second is the Angry Child (AC) mode, which emerges in spontaneous angry (or even rageful) reactions to unmet needs. The AC mode can be thought of as an early manifestation of a coping reaction, and its function is a protective one. However, just like other coping reactions (and coping styles), it often fails to achieve its intended goal. When either the AC or the IUC modes are present, ST calls for empathic yet firm limit setting. It also calls for an empathic exploration to discover the unmet needs (which typically underlie the AC mode) or to distinguish whims and wishes from needs (if the IUC mode is present).

Coping Modes Like the Child Modes described above, Maladaptive Coping Modes also represent behavioral states that become full-blown modes due to repeated activation. But whereas Child Modes (and particularly the VC) capture the helpless and muted emotional reactions of the child, Coping Modes develop out of a child’s basic survival operations: they are primarily automatic adaptation-promoting measures taken in order to survive in an emotionally negligent or otherwise noxious environment.

Maladaptive Coping Modes correspond to the three coping styles (overcompensation, avoidance, or surrender). For different individuals, these modes may take on varied forms: overcompensation may come across as grandiose self-aggrandizement, or as perfectionistic overcontrol, avoidance as emotional (and sometimes dissociative) detachment or as behavioral inhibition, and surrender as compliance and/or dependence.

A prominent avoidant Coping Mode is known as the Detached Protector. This mode disconnects clients from emotions – painful ones, but also adaptive ones such as sadness over a loss, assertive anger over a violation, feelings of closeness to others, or a sense of vitality and motivation. The Detached Protector can take the form of feeling numb, cut off from others and/or oneself, or feeling nothing at all. Clients in this mode may also engage in various behaviors aimed at distracting from or avoiding emotion: self-isolation, emotional eating, excessive drinking, or drug use. A goal of ST is to bypass the Detached Protector so that the therapist may make contact with the VC mode.

The Detached Protector is often present in individuals prone to dissociation and avoidance (e.g., ones with BPD). Other clinical groups are characterized by other coping modes. For example, the Self-Aggrandizer, often seen in narcissistic personality disorder, is an overcompensating Coping Mode meant to bolster the fragile self-esteem of a shame-filled Vulnerable Child. The Bully/Attack Mode, often seen in individuals with antisocial traits, is a more extreme adult version of the Angry Child mode. The Compliant Surrenderer, typical of individuals with dependent personality traits, is an example of a surrender Coping Mode.

Once established, coping modes continue to be deployed when schemas are triggered, as a way of coping with the ensuing distress. Paradoxically, though, coping modes lead to schema maintenance, by blocking the opportunity for new corrective emotional learning. Thus, they are considered, by definition, maladaptive and are typically seen as a cause of much, if not most, present-day problems. It is important to note, however, that coping modes involve behaviors that were, at some point, adaptive responses to difficult (or even impossible) interpersonal environments. Still, when this mode becomes the main tool for coping with stressful situations later in
life, it ceases to be adaptive. In ST, the therapist uses empathic confrontation to help clients recognize the costs involved in the inflexible use of such modes and to reduce their reliance on these modes.

**Parental Modes** A third and more pernicious class of modes are the **Internalized Dysfunctional Parental Modes**. Through processes of introjections and implicit learning through modeling, children learn to treat themselves as their early environment treated them — ways that are often quite dysfunctional. Of course, though the term chosen by Young to label these modes points directly to the parents as their source, not all critical, punitive, or demanding self-states result from direct internalization of parental figures. At times, it is broader society’s messages regarding some aspect of the self, present in the child, that are internalized to create one of these vicious, self-deprecat ing self-states (e.g., an internal homophobic self-state). At other times it might be a harmful non-parental person or a peer group with whom the child had some direct contact (e.g., sexual abuse perpetrated by a stranger, ostracism within one’s social milieu). Still, good-enough parental support in such adverse circumstances tends to mitigate their long-term negative impact dramatically, resulting in much weaker internal influence of malevolent self-states.

ST recognizes two prototypical forms of Internalized Parental Modes: a **Punitive Parent** and a **Demanding/Critical Parent**. In the former, individuals become aggressive, intolerant, impatient, and unforgiving toward themselves (or others), usually due to the perceived inability to meet the mode’s standards. In the latter, they may feel as if they must fulfill rigid rules, norms, and values and must be extremely efficient in meeting all these. In either mode, individuals might become very critical of self or of others and, as a result of the VC Mode’s co-activation, may also feel guilty and ashamed of their shortcomings or mistakes, believing they should be severely punished for them (Arntz and Jacob 2012). Clinically, ST works toward helping clients recognize these parental modes, come to view them as ego-dystonic voices, assertively stand up to their punitiveness or criticism, and learn to protect and shield the VC mode from their destructive effects.

**Healthy Adult Mode** Alongside painful child modes, maladaptive coping modes, and dysfunctional parental modes, most people also have self-states that are healthy and positive. We discussed one (the Happy Child mode) earlier. The other, referred to as the **Healthy Adult (HA) mode**, is the part of the self that is capable, strong, and well-functioning. When parents do an adequate job meeting the child’s basic needs, they model a healthy adult approach (instead of a punitive, demanding, or neglectful one). Indeed, for many clients, the HA mode is modeled after these positive aspects of their caregivers. For others, who lacked such models, the task of constructing such a mode is more challenging, yet not impossible. In fact, a major aim of ST is to have the therapist’s behaviors, and particularly their limited reparenting efforts, serve as a model for the development or reinforcement of this mode.

The Healthy Adult mode, like an internalized good-enough parent or therapist, has to respond flexibly to the various other modes. It nurtures, protects, and validates the VC mode, sets limits on the impulsivity and the angry outbursts of the angry and impulsive child modes, negotiates with maladaptive coping modes so as to limit their presence, and combats the effects of dysfunctional parent modes.

**Empirical Support**

The efficacy of individual ST as a treatment for several disorders, particularly personality disorders, has been demonstrated in several studies to date (e.g., Giesen-Bloo et al. 2006; Nadort et al. 2009; Bamelis et al. 2014). Additionally, very promising results emerged for the use of ST in a group format with BPD patients (Farrell et al. 2009) and for individual ST in the treatment of chronic depression (Malogiannis et al. 2014). Overall, the evidence for the efficacy of ST can be considered promising but preliminary, as there have not yet been any direct replications of the RCTs reviewed above.
Although tests of ST as a complete intervention package provide indirect support for the utility of the theoretical model, more research is needed to further validate it as a model of pathology. Some research into the reliability and validity of modes has been conducted (see Lobbestael 2012; Sempértégui et al. 2014, for reviews), mainly centering on the development of the Schema Mode Inventory (Lobbestael et al. 2010), a measure of 14 clinically relevant schema modes. Using this measure, modes have largely been found to relate to personality disorders in theoretically coherent ways (Lobbestael 2012). For example, patients with BPD have been found to be higher in the frequency of the Abandoned/Abused Child, the Punitive Parent, the Detached Protector, and the Angry Child than both healthy controls and Cluster C personality disorder patients. Experimental studies (Arntz et al. 2005; Lobbestael et al. 2009) have begun to validate the theory that modes are state-like experiences that occur in response to triggers in the environment and much more so for personality disorder patients. More work is needed to show that in addition to activated emotion, modes also involve characteristic ways of thinking and behaving. Finally, a priority for research into the mode model lies in the area of process-outcome research within intervention studies, to demonstrate that in-session mode states can be reliably recognized and, further, that working actively with modes transforms underlying schemas and leads to lasting mental health.

Summary

ST is an integrative therapeutic approach used in the treatment of long-standing personality disorders and relational difficulties. The etiological/developmental theory underlying it shares many of the assumptions of attachment theory as well as object relations, self-psychology, and relational psychoanalysis. Its pragmatism stems from Beck’s cognitive therapy, from which it emerged (see Rafaeli et al. 2014). The experiential techniques used within it are rooted in gestalt and process-experiential approaches. Finally, its current emphasis on a multiplicity of modes (or self-states) corresponds quite closely to various models within personality and clinical psychology which highlight the non-unitary nature of the self.

References


