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CHAPTER 12

Working with Modes in Schema Therapy

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> We do not have one mind, but many—at any one time, one of these minds may be dominant, and can be thought of as the current mind-in-place.
>
> —JOHN D. TEASDALE (1997, p. 70)

William James (1950) distinguished between the known self (*me*) and the knower self (*I*). This distinction has been complemented in recent years by the understanding that both the knower and the known are themselves multiple in nature, and not unitary. Though a monolithic conception of the self still permeates our culture and though we continue to refer to ourselves using the singular form, clinical theorists from diverse orientations (e.g., Berne, Bromberg, Greenberg, Perls, Young) recognize this multiplicity of the human self. This chapter describes an approach—schema therapy's mode model—that is based on a particular understanding of this multiple self.

Schema therapy (ST) is an integrative model of psychotherapy; and ST work based on the mode model (a.k.a. *mode work*) is a prime example of this integration. The etiological/developmental theory underling ST shares many of the assumptions of attachment theory as well as psychodynamic theories, such as object relations, self psychology, and relational psychoanalysis. Its pragmatism stems from Beck's cognitive therapy, from which

it emerged. The experiential techniques that play a central role in mode work are rooted in gestalt and process–experiential approaches. Finally, the objectives of mode work are both experiential and cognitive, and it (like all of ST) makes extensive use of relational, cognitive, behavioral, and experiential tools.

This chapter begins with a theoretical introduction to the ST mode model. We explain how the mode concept has become central to the practice of ST, and present the taxonomy of modes, along with a developmental account of their etiology. We then review the extant evidence for the mode model. The greater part of the chapter illustrates the clinical work that stems from this model—that is, mode work. We conclude with a discussion of the limitations of this work and the future directions we hope it takes.

Background and Theory

ST and the Introduction of the Mode Concept

ST grew out of Beck's cognitive therapy, gradually developing into a unique integrative treatment for a spectrum of long-standing emotional/relational difficulties, most notably personality disorders. ST was developed by Young (1990) to address roadblocks to progress encountered when working within the Beckian model with clients suffering from chronic difficulties with mood (e.g., dysthymia) and chronic interpersonal problems (e.g., personality disorders). As Young discovered, cognitive therapy with nonresponders and relapse-prone clients required shifting the focus from surface-level cognitions or beliefs to deeper constructs—namely, *schemas*—as central to understanding psychopathology.

Schemas are considered to be 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 his colleagues (Young, Klosko, & Weishaar, 2003) proposed a taxonomy of early maladaptive schemas that are thought to emerge when core emotional needs go unmet or are met inappropriately, usually by a child's caregivers.[1] 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. Young posited that enduring client problems often stem 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

[1]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.

the characteristic behaviors enacted as a response to the schema—which Young referred to as "coping styles."

Starting in the mid-1990s, Young (e.g., McGinn & Young, 1996) began recognizing the necessity of revising ST to move beyond its predominant focus on universal *needs,* pervasive *schemas*, and characteristic *coping styles*. Needs, schemas, and coping styles 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 with borderline or narcissistic personality characteristics, who manifest quick and often intense fluctuation among various self-states or moods. This led to the development of the *mode* concept.

Young et al. (2003) defined *modes* as the predominant schemas and coping reactions 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 of the spectrum, modes could be like moods (e.g., a woman may feel somewhat down and lonely for an afternoon, but gradually feel her mood lift by the evening). At the most extreme end, a total separation and dissociation could exist between modes (e.g., each mode may entail a complete and different personality, as is the case in dissociative identity disorder, formerly known as multiple personality 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, van Vreeswijk, & Arntz, 2008; Shafran et al., 2014). 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 & Jacob, 2012).

Modes as Self-States

How does the structure of multiple modes develop, and how does it ultimately lead to an integrated, coherent person? Developmental theorists have suggested that a well-integrated self is the brittle outcome of tremendous integrative efforts made by the developing mind (cf. Putnam, 1989; Siegel, 1999). 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 (or "states-of-mind"; Siegel, 1999) can be defined as 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. The benefit of such cohesion is quite clear: it maximizes the efficiency and efficacy of the processes needed in a given moment in time to deal with a current situation (Siegel, 1999).

States (or states-of-mind) start off as unique and ad-hoc combinations of mental faculties organized in response to discreet challenges or situations in the child's life. However, situations tend to repeat themselves and thus repeatedly activate the same states. Over time and with repeated activation, basic states of mind cluster together into self subsystems; as Siegel (1999) noted, the repeated reactivation of the same state of mind makes it evolve into an ingrained and separate "self-state." These self-states thus serve as the early prototypes of what ST refers to as "modes," which we continue to encounter throughout life. Below, we review the major categories of modes discussed by ST: (1) child modes, (2) coping modes, (3) internalized parental modes, and (4) the healthy adult mode. We also note the current thinking regarding these modes' etiology and briefly explain how ST works with each mode.

A Taxonomy of Modes and Their Etiology

Child Modes

When a child's needs are, on balance, appropriately met, the ensuing self-states tend to be flexible and adaptive. With repeated exposure to situations in which emotional needs are met, emotions can become regulated, distress is soothed, and the child (and later the adult) gains access to a *Happy Child mode*. In this mode, the person contacts capacities for closeness, trust, and contentment, and is able to draw on inner sources of vitality, spontaneity, and positive motivation. Toddlers, for example, are relentlessly curious and frequently joyful. Though their innate feelings and motivations may no longer be very accessible for adult (or even adolescent) clients whose parents failed to foster such curiosity and joy, ST seeks to reconnect clients with their Happy Child mode by removing barriers to these feelings or creating the opportunity to develop such feelings if no such opportunity existed in childhood.

When a child's needs do not get met in an adequate manner, a self-state referred to as the *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. For example, when the childhood needs for safety and security were frequently met with frightening parental behaviors (e.g., anger or violence), the VC mode will be characterized by fear and anxiety about close relationships. When needs for empathy and validation were countered with no understanding or acknowledgment of the child, a client's VC mode will reflect a chronic sense of loneliness and of being unseen or easily misunderstood by others. When needs for praise and encouragement were met with frequent blame and criticism, the VC mode will contain feelings of shame, a lack of self-worth, and an expectation of further blame and criticism.

The VC mode, rooted in childhood experiences, can often be triggered in an adult's life. "Triggers" are situations that bear varying degrees of similarity to the originating experience (e.g., aversive or ambiguous interpersonal interactions). When these situations occur, clients essentially reexperience an earlier trauma, typically of a relational kind (Howell, 2013). The reexperiencing 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 aims to help 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 owing 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. At times, coping modes may emerge less in response to a depriving or abusive environment, and more as an internalization of it. For example, a child whose parents employ perfectionistic overcontrol in their own lives may herself learn to employ this coping style or mode—or more accurately, will fail to learn any alternative ways of being.

Maladaptive coping modes correspond to three coping styles (avoidance, overcompensation, or surrender), which parallel the basic organismic responses to threat: flight, fight, or freeze (Young et al., 2003). For different individuals, these modes may take on varied forms: avoidance may come across as emotional (and sometimes dissociative) detachment or as behavioral inhibition; overcompensation as grandiose self-aggrandizement or as perfectionistic overcontrol; 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, or 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 VC. 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. For example, a young child of verbally brutal and physically abusive parents has little choice but to switch into a detached self-state, which may at least minimize the pain and reduce additional confrontations with the abusers. The resultant Detached Protector (i.e., avoidant) mode was essential for survival under those harsh circumstances. Still, when this mode becomes the main tool for coping with stressful situations later in life, it ceases to be adaptive (for similar ideas stemming from a relational psychoanalytic perspective, see Bromberg, 1998). 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 the process of introjection, which incorporates principles of implicit learning through modeling (e.g., Bandura, 2006), children learn to treat themselves the way their parents treated them—ways that are often quite dysfunctional. Internalized parental modes represent distinct ways in which individuals may be their own worst enemies—a phenomenon recognized by many clinicians, with terms such as punitive super-egos (Freud, 1940), internalized bad objects (Klein, 1946), malevolent introjects (Chessick, 1996), perpetrator parts (van der Hart, Nijenhuis, & Steele, 2006), or internal critics (Greenberg & Watson, 2006).[2]

ST recognizes two prototypical forms of internalized parental modes: a *Punitive Parent (PP)* and a *Demanding Parent (DP)*. In a PP mode, the client becomes aggressive, intolerant, impatient, and unforgiving towards himself (or others), usually due to the perceived inability to meet the mode's standards. When in a DP Mode, he might feel as if he must fulfill rigid

[2]Although the titles chosen by Young to label these modes point directly to the parents as their source, neither we (nor Young himself) took it to imply that all critical, punitive, or demanding self-states are indeed the result of direct internalization of parental figures. At times, it is the broader society's messages regarding some aspect of the self, present in the child, that are internalized to create a vicious self-deprecating self-state (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.

rules, norms, and values and must be extremely efficient in meeting all of these standards. In either mode, he might become very critical of self or of others, and, as a result of the VC mode's coactivation, may also feel guilty and ashamed of his shortcomings or mistakes, believing he should be severely punished for them (Arntz & Jacob, 2012). The goal in ST is to help the client recognize these modes, come to view them as ego-alien 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 of 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 therapists' 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 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 AC and IUC modes, negotiates with maladaptive coping modes so as to limit their presence, and combats the effects of dysfunctional parent modes.

Modes become activated in response to environmental triggers, but also in response to each other. For example (see Figure 12.1), a friend's cancellation of a date (abandonment schema cue) (1) triggers the VC mode (feeling lonely and sad), leading to (2) the activation of a PP mode (feeling it's all my fault and also that feeling so sad about it is a terrible sign of weakness or stupidity). This, in turn, might lead to (3) even stronger activation of the VC mode, culminating either in (4a) an impulsive or rageful gesture, such as lashing out at the friend, or in (4b) an emotional shutdown using alcohol or drugs (Detached Protector coping mode).

Research Evidence

ST as a whole has undergone several recent empirical tests. Since the mode model is now the primary organizing framework for ST, these tests offer promising though indirect evidence for the effectiveness of the model in

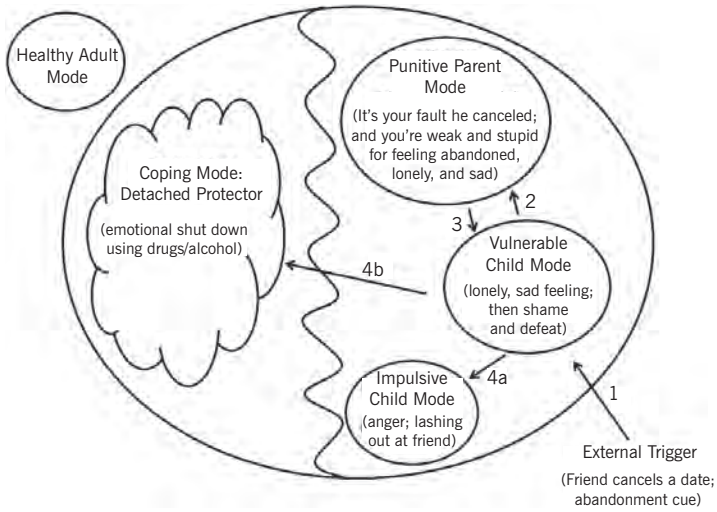

FIGURE 12.1. Illustrative model of a client's characteristic mode activation sequence.

clinical work. In the first major test of ST, Giesen-Bloo et al. (2006) conducted a multicenter randomized controlled trial of ST versus transference-focused therapy (TFP), a psychodynamic therapy, in the treatment of 86 patients with BPD, treated twice weekly for a period of 3 years. A significantly greater proportion of patients were found to be recovered or reliably improved in BPD symptoms at the end of treatment in the ST arm (45.5% recovered and 65.9% improved) than in the TFP arm (23.8% recovered and 42.9% improved). Given that patient retention is notoriously difficult in the treatment of PDs, it is important to note that dropout rates were considerably lower in ST (25%) than in TFP (50%). Among those who dropped out, ST patients had a median of 98 sessions (close to 1 year) while TFP patients had a median of 34 sessions (roughly 4 months).

These findings are notable as it is relatively rare for one active treatment to do significantly better than another in head-to-head trials (e.g., Baardseth et al., 2013). Extending the generalizability of these findings, Nadort et al. (2009) conducted a feasibility study with 62 patients with BPD in which the patients were randomly assigned to two conditions, with or without between-session phone contact with the therapist. There was no difference in outcome, indicating that it was the within-session work that contributed to outcome. Overall, the treatment was found to be feasible and effective when delivered in the community, with 42% of patients reaching recovery from BPD after 1.5 years of treatment.

In another multicenter RCT, Bamelis, Evers, Spinhoven, and Arntz

(2013) extended the mode model to patients with avoidant, dependent, obsessive–compulsive, paranoid, histrionic, and/or narcissistic PD. A total of 300 patients were randomized to either ST, psychodynamically oriented treatment-as-usual (TAU) in the community, or clarification-oriented psychotherapy (COP). At the end of 2 years of treatment ST had significantly better outcomes than TAU and COP, with PD recovery rates of 81.4%, 51.8%, and 60.0%, respectively. Interestingly, a moderator effect showed that the second of two cohorts of schema therapists drove the positive findings. This second cohort was trained more extensively in implementation of various ST techniques, including experiential ones. Initial process ratings validate that these therapists did use more of the ST techniques than the earlier cohort. This provides initial evidence that it is methods of actively evoking modes (which allow working with emotion) that serve as key active ingredients. Several other trials are underway of ST, focusing on forensic populations, chronic depression, and posttraumatic stress disorder (PTSD). Preliminary analyses from each of these suggest results that are quite positive. Additionally, very promising results emerged for the use of ST in a group format with patients with BPD (Farrell, Shaw, & Webber, 2009), and preliminary results from an international multicenter replication study of group ST bolster the excitement about the group modality. Finally, some additional (though smaller) effectiveness studies have also yielded positive results (see Bamelis, Giesen-Bloo, Bernstein, & Arntz, 2012). 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.

Though tests of ST as a complete intervention package provide indirect support for the utility of the mode 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, for a review), mainly centering on the development of the Schema Mode Inventory (Lobbestael, van Vresswijk, Spinhoven, Schouten, & Arntz, 2010), a measure of 14 clinically relevant schema modes. This measure taps the main modes discussed in the present chapter but offers further differentiation of some modes (e.g., differentiating the Angry Child and the Enraged Child). Using this measure, modes have largely been found to relate to personality disorders in theoretically coherent ways. 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 PD patients. Experimental studies involving watching a traumatic film clip (Arntz, Klokman, & Sieswerda, 2005) as well as anger induction experiments (Lobbestael, Arntz, Cima, & Chakhssi, 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 patients with PD. More work is needed to show that in

addition to activated emotion, modes also involve characteristic ways of thinking and behaving. Finally, a clear priority for empirical investigation of the mode model lies in the area of process–outcome research, 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.

Application of Mode Work

Overview

Mode work—and a conceptualization based on modes—has become central to ST in the last two decades. This is obviously the case when clients are characterized by strong fluctuations among various modes, but is also true with clients for whom modes are less volatile. In either case, when schema therapists engage in mode work, they attend to the specific modes present in the therapy room—and those that appear in "real life." In collaboration with the client, the therapist labels these modes, explores their origin, and links them to current problems. Over time, the client is encouraged to consider and experiment with the possibility of modifying or even giving up some modes.

A unique aspect of ST is its emphasis on deliberately inviting or activating all of a client's modes, including the maladaptive ones, in session. Schema therapists seek to give voice to various modes, to differentiate them, and to use experiential techniques to set up deliberate interactions between these normally dissociated self-states. This "hot" emotional activation of the client's neural and cognitive circuitry is seen as essential for affecting change for deeply rooted, long-standing problems.

Conceptualization

ST begins with an initial period of assessment which typically requires four or five sessions but at times may be much longer (cf. Rafaeli, Bernstein, & Young, 2011). Assessment often involves informal history taking, administration of questionnaires (such as the Young Schema Questionnaire; see Rafaeli et al., 2011, for more details), assignment of thought and mood monitoring to obtain examples from daily life, as well as the use of imagery techniques for assessment (described below). At the conclusion of the assessment phase, and as a guide to the intervention phase, a case conceptualization, which is developed collaboratively by therapist and client, is created. In it, the problems and symptoms reported by the client or identified by the therapist are recast using the concepts of needs, schemas, coping responses, and (most pertinently) modes. The process of jointly conceptualizing the problems provides considerable psychoeducation (e.g.,

about the universality of needs, about the ways in which schemas get maintained throughout life). It involves exploring the origins of the schemas and modes, as well as the ways in which they are tied to present-day problems. A good conceptualization "fits well"—it eschews jargon and instead labels schemas and modes using terms that are understandable, even familiar, to the client—and may indeed come *from* the client. Several recent books and chapters (e.g., Rafaeli et al., 2011; Arntz & Jacob, 2012) discuss the conceptualization process in detail.

The conceptualization helps both the client and the therapist differentiate, identify, and name the relevant modes that play a part in the client's experience. Differentiation is key to mode work, as ST prescribes very different responses to modes of various types. Vulnerable, Impulsive, Angry, and Happy child modes are responded to with relevant forms of *limited reparenting* (appropriate nurturance and protection; limit setting; encouragement for ventilation along with limit setting; and playful joining, respectively). Maladaptive coping modes are responded to with *empathic confrontation* (empathy for the difficulty or distress that prompted the coping response, and for the typical feeling that "there's no other choice," along with confrontation toward the maladaptive behavior itself). Internalized dysfunctional parental modes are confronted so that they become *externalized* and ego-dystonic. Finally, the healthy adult mode is responded to with recognition and mirroring, along with modeling of additional adaptive parental responses. At first, the differential response to modes may be the therapist's purview. However, over time, the therapist models this differential response and the client's Healthy Adult internalizes and practices it.

Mode Work as a Form of Structural Therapy

The ST conceptualization culminates in a treatment strategy, which usually centers on the client's modes. The strategy suggests ways of altering the overall configuration of modes and the relative dominance or power of specific modes. We use the metaphor of structural therapy here, as it emphasizes the idea that in ST, we view the person as a system, comprising multiple and mutually interacting modes. Our aim is to change the way these parts work together. In broad terms, this requires three key processes: clarifying what the modes are; giving voice to adaptive and vulnerable modes; and creating adaptive boundaries between the modes. One technique often used in ST to facilitate all three of these processes is chairwork (Kellogg, 2004), and in particular, two-chair dialogues.

Shifting the Balance between Modes: Two-Chair Dialogues

Chairwork began as a technique within psychodrama and Gestalt therapies (e.g., Carstenson, 1955; Perls, 1973) and has been adopted by several

therapy models influenced by Gestalt, including ST (Young et al., 2003). In ST chairwork, the client is encouraged to conduct dialogues (or broader conversations) among different parts of the self (internal conversations) or between the self and a meaningful external figure (external conversations), while actively moving between different chairs; modes, figures, or parts are situated in different chairs. The client is encouraged to take on each chair (i.e., each mode or figure) fully—expressing that mode's views wholeheartedly and responding to the other present modes forcefully from that mode's perspective. Once one mode's views and responses are clear, the client moves to another chair and takes on that chair's (i.e., that mode's) viewpoint.

A typical example of such work may involve a two-chair (internal) dialogue between the Vulnerable Child mode and the Demanding Parent mode for a client who has a prominent defectiveness schema related to her sexual orientation and obesity. In it, the client may be invited at first to voice the internalized parent's criticism and demands. In the parental seat, she will verbalize the harsh and demeaning messages she received (and still receives) from her father. Once these are voiced, the client would switch to the child seat, and respond to these messages. The therapist would encourage the client to express her emotional reactions to the parental voice, rather than argue the facts with it. The client may switch back and forth several times, until both modes' viewpoints are fully expressed. The therapist ensures that the child mode ultimately asserts its needs and confronts the parental mode. However, it is essential to also ensure that the parental mode is not permitted to "hide its cards"—we want to confront it in its fullest and strongest form.

Two-chair dialogues emphasize direct contact between modes. When in one mode, the client is asked to speak directly to the mode "sitting" in the opposite chair. To do so, the therapist may instruct the client to imagine the look, sound, and feel of the mode as it "sits" in the opposite chair, assigning person-like qualities to it. For example, a Demanding Parent mode could have a stern, contemptuous look with a crinkled brow. Should a client have difficulty staying with a particular mode, the therapist may help clarify that mode's voice. For example, the therapist may suggest certain phrases that seem consistent with the mode's viewpoint, or help name feelings as they arise, so that they become verbalized. Additionally, when the client seems to begin voicing another mode's position, the therapist may motion for her to change seats (thus avoiding "cross-talk").

The simplest and most common use of chair dialogues involves two chairs, but ST mode work may at times involve three, four, or even more chairs. For example, a therapist may find it useful to pull in a separate chair on which the client's coping mode would sit. In it, the client might be encouraged to voice his typical behavioral coping reaction to the parental punishment or criticism (e.g., disengagement, surrender, escape). Dialogues between this mode and the child mode (and/or the therapist) can

be very informative, especially among avoidant, compliant, or dependent clients. Once the coping mode's voice is made clearer, the therapist may use empathic confrontation with it, so that it steps aside to allow the key drama between the child and parent modes to play out. Other modes that may warrant their own chair at times are the Angry Child mode, the Healthy Adult, or the internalized representation of another parent or significant other who was experienced as psychologically different. In our earlier example, this may involve pulling in a chair for the client's helpless and passively neglectful mother, in addition to the chair representing the abusive and critical father.

Chairwork is inherently psychodramatic. This dramatic nature can be further enhanced by attending to the dramaturgy of the chairs' physical placement. The confrontation of maladaptive modes versus healthy or vulnerable ones is easier to see when these chairs are placed oppositely. Therapists can convey their support and encouragement for certain modes (e.g., the vulnerable child or the healthy adult) by situating themselves closer to these chairs. Finally, the buffering (and interfering) role of coping modes can be illustrated well by placing their chair(s) in awkward middle spaces (e.g., at 90° to the other chairs).

Common Mode Work Interventions

ST resembles structural therapy in its systemic outlook on the multiplicity of self-states or modes and on the need to create systemic change that would be reflected in a changed structure. Unlike systemic approaches, however, ST does not shy away from seeing particular units within the broader structure as needing specific interventions. Below, we illustrate three types of mode work interventions, which center respectively on coping, parental, and child modes.

Overcoming and Bypassing Coping Modes: Imagery for Assessment

Coping modes emerge early in life to protect or shield the vulnerable child. Over time, they become ingrained and inflexible, and often begin to serve as the client's "greeting card." For example, a narcissistic client with a lonely/inferior child mode may find it almost inconceivable to allow this mode to be seen by anyone, including his new therapist. Instead, he is likely to spend the majority of time, especially early in therapy, in a compensatory Self Aggrandizer mode. The keys to the sports car would be prominently displayed; the therapist's education and credentials would be arrogantly questioned; and sessions would often feel like bouts of verbal sparring. These behaviors interfere with the most basic tasks of therapy—building rapport and trust, clarifying the client's needs and distress, and formulating a plan of action.

To address such maladaptive coping behaviors, ST advocates empathic confrontation. Often, such confrontation utilizes cognitive or behavioral methods (cf. Arntz & Jacob, 2012). For example, the therapist might encourage the client to identify and label the coping mode or to draw up a list of pros and cons for maintaining it. However, emotion-focused interventions can be a part of empathic confrontations. One such intervention—the inclusion of a separate chair for the coping mode within multiple-chair dialogues—was described above. Here, we will present a second emotion-focused technique, *imagery for assessment*, used early in therapy to bypass coping modes. (This technique is also mentioned, briefly, by Arntz in Chapter 8, this volume, where it is referred to as *diagnostic imagery*).

When therapists use imagery as an assessment tool, they invite the client to shut his or her eyes and to visualize certain scenes, memories, or experiences in a vivid way. The client is asked to verbalize what he or she sees, hears, and feels, and to do so as if the client is present in the scene (thus, speaking in the first person and the present tense). The purpose is for the client to become absorbed in the scene—to "be" in it, rather than to relate to it from a distanced perspective.

With the narcissistic client described above, as with most clients, imagery for assessment might be introduced early (by Sessions 5–6). The therapist begins by presenting the rationale for using this technique, emphasizing its utility: identifying and triggering the client's needs and schemas, clarifying the childhood origins of these needs and schemas, and helping tie the client's presenting problems to his needs and schemas. After presenting the rationale, the client is invited to imagine a safe place. This allows the client to experience imagery first within a nonthreatening scene, and also creates a safe haven to which the client can return at the completion of the imagery exercise, or at any intermediate point in which he feels too activated. The therapist may help the client construct a safe image if one is not forthcoming (e.g., by suggesting calm natural scenes that often work well). At times, the client may simply be encouraged to close his eyes and simply imagine the therapy room itself.

Once the safe place is sufficiently experienced, the therapist asks the client to let an image of an upsetting childhood situation enter his mind. Little guidance is given, other than asking that this be an image of a time or place from before the age of 9–10, and that it involve the client with at least one of his parents or another significant person. The client is invited to immerse himself in the image, noticing his own thoughts, feelings, and bodily sensations. He is then invited to speak to the other people in the image, expressing his needs, thoughts, or feelings to the extent possible. He is asked to attend to the other person's verbal and nonverbal responses, and to carry out a dialogue between himself (as a child) and the other figure. This dialogue continues until the affect, need, or wish of the child are made

very clear; often, the other person's response (limited or deficient in many cases) also becomes clear.

After the childhood scene is sufficiently explored, the therapist asks the client to focus on the emotions or physical sensations that are most salient and to amplify them while allowing the actual scene to fade away. In its place, the client is asked to imagine a scene from his present-day life, in which the same emotions and physical sensations are felt. Once again, the client is asked to enter the imagined scene, immerse himself in it, and ultimately carry out a dialogue with whatever figures are present in this scene. Like in the childhood scene, this dialogue's objective is to activate and clarify the client's affect, needs, and wishes, and to get a sense of the other's responses. There's no expectation that resolution would occur. After the present-day scene is sufficiently explored, the therapist invites the client to return to the safe place image, which helps regulate elevated negative affect that usually arises during the imagined scenes.

We would like to note that when clients are summoning images from childhood, therapists should take care not to suggest elements in the imagery that were not present (e.g., abuse that did not take place), and thus lead the client to "create" false memories (cf. McNally, 2003). Additionally, while therapists offer considerable validation to the emotions felt during imagined scenes or memories, they should be mindful not to assume automatically the veracity of these memories (nor to inculcate such an assumption in their clients). At this point in the work, what is most important is not finding out exactly what happened in the past, but rather how it felt for the client and what meanings he took from his past experience.

Arntz (Chapter 8, this volume) goes into many of the general practical issues related to the use of imagery techniques at various times. Though we focus specifically on imagery for assessment as a technique used to bypass coping modes, it should be said that other forms of imagery work (including imagery rescripting, detailed by Arntz and noted below) and can also be used with the same purpose, at any stage of the therapy. Certainly, coping modes continue to exert their influence long after the assessment phase. Nonetheless, the basic architecture of an assessment imagery exercise is a useful one to keep in mind; it can serve as the template around which future imagery exercises are improvised.

Imagery for assessment can (and should) be repeated, so as to access affect and memories tied to all parents or caregivers. One benefit of doing so several times early in the course of therapy is that it sets the stage for future emotion-focused work. In a way, introducing imagery exercises early in the assessment phase socializes clients to the rhythm and style of a therapy focused on experience, rather than on cerebral discussion. This, in its own right, is a challenge for the avoidant coping modes of many.

Confronting Parental Modes: Imagery with Rescripting

Dysfunctional Parental modes are the echoed voices of key external figures. These figures, typically caregivers, can be the father who denigrates his daughter; the mother who conveys a sense of conditional regard (*You are worthy only if you fulfill* my *needs or expectations*); the peer group who ostracize or bully a newcomer. Tragically, the damage done by these figures at an early impressionable age is perpetuated by those parts, within the adult client, that learned or internalized the lessons too well. An important ST goal is to help clients recognize these pernicious voices of self-criticism and self-punishment as ego-alien in nature, and to help them fight and (if possible) even banish these voices.

To do so, schema therapists place themselves squarely on the side of compassion and self-acceptance—that is, on the side of the (sometimes barely nascent) Healthy Adult. Together with the Healthy Adult, they attempt to dislodge internalized voices that purport to have a monopoly on "truth," "values," or "standards," but in fact use these to oppress, devalue, or torment the client (and particularly the client's VC).

A variety of tools can be deployed in ST for this purpose. They include cognitive and psychoeducational efforts to identify and label these modes, help understand their origin, and begin building the case *against* them and *for* an alternative view of truth, values, and standards; behavioral techniques aimed at changing specific habits tied to these modes (e.g., working with a self-critical client to deliberately schedule more leisure time or to engage in pleasurable activities); and the use of the therapy relationship as a source of (limited) reparenting that models the antithesis of dysfunctional parenting. Yet ST's most powerful tools for combating the Dysfunctional Parental modes are experiential techniques, particularly chairwork (described elsewhere in this chapter) and imagery with rescripting (ImRs; described in detail by Arntz, Chapter 8, this volume; see also Arntz & Jacob, 2012). We will therefore limit our discussion of this technique to a few general points that may help to situate it as part of the broad ST modework strategy, and to distinguish between ImRs and assessment imagery (described above).

1. When describing imagery for assessment, we noted that a typical sequence begins with an upsetting image from childhood and proceeds to an upsetting image from current life, linked through the affect experienced in the two scenes (the "affect bridge"). This progression reinforces an important ST lesson regarding the childhood origins of present-day distress, unmet needs, and maladaptive schemas. This sequence, however, is not set in stone, and in ImRs is often reversed or not followed in full. For example, if a client enters a session already upset about a current situation, we would use imagery of this situation as the starting place and then work

back in time, asking the client to get an image from childhood that feels the same. We could also use images of specific symptoms or of hard-to-understand feelings as starting points. For example, we might say, "Can you focus on the tears that are coming up now? What could these tears be saying?"

2. Imagery in general, and ImRs in particular, may exert its effects through several mechanisms (e.g., reattribution and emotional processing, reviewed by Arntz, Chapter 8, this volume). One additional potential mechanism noted by many schema therapists is that imagery activates affect in both the client and the therapist, simultaneously. The importance of "hot" versus "cold" cognitive processing by the client is well documented (see Thoma & Greenberg, Chapter 11, this volume). However, the evocation of affect in the therapist may also play an important role in increasing the empathy and attunement he or she provides. Moreover, the activation of a shared emotion (e.g., the client's and the therapist's anger) regarding a shared focus (e.g., the dysfunctional parent's behaviors in the scene) may play an important ameliorative part, in providing patently evident validation for the client.

3. When therapists request permission and enter an image, they typically do so with two purposes: to nurture the VC and to confront or combat the internalized parent or perpetrator. ImRs does not always entail the latter: in some instances, the gentle care and attention given to the client's VC is key. It is important to note, however, that imagery is *never* focused only on the perpetrator, and *always* requires care and attention to the child; when confrontation is called for, we must stay cognizant of the experience—sometime terrifying, sometimes ambivalent—of the child who is witnessing it as it unfolds.

Giving Voice to the Angry or Vulnerable Child Modes: The Empty-Chair Technique

Among many clients, even those with ample reasons for hurt or angry feelings, the Vulnerable and Angry Child modes often sound very muffled or cannot be heard at all. These modes hold most of the client's distress and negative affect, but are often buffered or obscured by coping modes, or overpowered by internalized parental modes. When schema therapists recognize this silencing, they strive to give these modes greater voice: their hurt or angry feelings are the most direct expression of the client's unmet needs, and ST revolves around recognizing and validating these needs and finding ways to meet them inside and outside the therapy room. Few therapeutic aims are more important than this.

Like all ST aims, this can be achieved in a variety of ways. Therapists' care and validation (key parts of the limited reparenting stance) are

expressly directed at the client's vulnerable parts. Two-chair and imagery techniques aimed at strengthening the HA, curtailing the effects of coping modes, or combating Internalized Parental modes also carry an empowering message to the hurt VC. Various cognitive tools (e.g., schema flashcards) can help convey the psychoeducational message that vulnerabilities (and the unmet needs that underlie them) are themselves a healthy, if painful, response. But a key emotion-focused way of empowering the child modes is the *empty-chair technique*.

In empty-chair work, therapists help clients express their hurt or angry feelings towards an external person, while imagining this person to be present and sitting in another chair in the room. The imagined other here is typically a real person—a neglectful or punitive caregiver, an uncaring authority figure, or a vicious perpetrator. Inviting clients to confront such a person (even if only in imagined form) tends to activate very strong affect. This activation is of course essential for the salutary effects of this work, but the invitation to experience it may not be met with great enthusiasm from many clients. Clients are often aware cognitively of the hurt or anger, but shy away from experiencing them strongly or from expressing them. They may be terrified of the emotions or hopeless about the prospect that letting them out would lead to anything but more grief. Moreover, the dramatic and performative aspects of this technique may make some clients balk at using it. These are formidable concerns and should be carefully addressed; chair-work of this sort should be preceded with a clear presentation of the rationale for this work, and requires the client's consent before proceeding with it.

Early in this work, the therapist strives to ensure that the client vividly and directly experiences the other person—in Gestalt terms, that *contact* was established (cf. Elliott, Watson, Goldman, & Greenberg, 2004). This may be done with brief imagery instructions (e.g., "Close your eyes and imagine your mother there. What does she look like? What expression do you see on her face? What can you tell from her body language?"). It could also involve having the client alternate seats, expressing his own needs and feelings from one seat, and responding to them as the other person (e.g., the mother) would respond. Hearing the imagined other's responses tends to imbue the work with more affect, which usually facilitates the process.[3]

Once the imagined other is evoked, the client is encouraged to express his feelings directly toward this person. The therapist gently directs the

[3]When the imagined other is the perpetrator of severe abuse, empty-chair work must be entered with great caution, and the therapist would be unlikely to suggest that the client alternate into the empty chair. Instead, the work may first tackle other significant others (e.g., a passive mother who did not shield the child from the perpetrator's actions). Additionally, while the client may need to express pain, hurt, and anger at the abuser, it would rarely be useful to express sadness (or a need for nurturance) to an abuser.

client away from abstract or experience-distant statements (e.g., "She wouldn't have agreed to have this conversation") and refocuses him on concrete, present-focused conversation (e.g., "Can you tell her what it's like for you to see that expression on her face right now?"). The main objective is to activate pent-up emotion in the client, and not to engage in a logical or factual argument with the imagined other. Additionally, the therapist emphasizes that this work will typically not culminate with any "real-world" change—that is, in the client's need suddenly being met by the other person. Such change is unlikely; instead, the client will benefit from learning (on an emotional level) that it *was their right* to have this need met. Helping clients disentangle what should have been (i.e., the need's validity) from what couldn't happen (i.e., the impossibility of getting it met) is a step toward accepting and mourning what cannot change.

In EFT, Greenberg and his colleagues (cf., Elliott et al., 2004; see also Thoma & Greenberg, Chapter 11, this volume) describe the use of chairwork in addressing "unfinished business," a broad category that includes unexpressed hurt and anger. They note the therapist's role in facilitating this process, and in particular, in ensuring that the feelings expressed are primary emotions (e.g., anger, fear, shame, and sadness), and not secondary ones (hopelessness, anxiety, complaint, or blame). Despite the difference in terms, the EFT formulation is similar to that of ST. Specifically, schema therapists encourage the activation and expression of the basic emotions felt by the (vulnerable or angry) child, which are tied directly to the child's unmet needs, rather than the processed secondary emotions that emerge from coping modes, which are tied more to these modes' maladaptive coping attempts.

In a review of chairwork techniques across several integrative approaches, Kellogg (2004) noted that some (e.g., Gestalt therapists) use it primarily for facilitative purposes (i.e., to increase awareness of unresolved difficulties), while others (e.g., CBT therapists) use it primarily for corrective purposes (i.e., to catalyze cognitive shifts). As Kellogg notes, ST pursues both purposes, and has a third, confrontational purpose: of directly combating maladaptive self-states. Young et al. (2003) place the greatest emphasis on this third purpose, and advocate using empty-chair dialogues to completely vanquish the Internalized Parental modes. Our experience is that at times, this technique can be followed with other aims in mind. This is particularly true with clients from more interdependent cultures, as well as with clients for whom the child mode is more mature and capable of holding on to an integrated (good *and* bad) image of the internalized parent. In particular, like Greenberg and his colleagues (cf. Elliott et al., 2004) we see many clients modify their view of the parental figure. At times, this leads to the shrinking presence of this figure or its impact (as Young et al., 2003, suggest); at other times, it opens the road for forgiveness or resolution.

Whereas the empty-chair technique is focused on an external other, opportunities ("markers," an EFT term) for this work often present themselves when using internal, two-chair dialogues. For example, when speaking as their own Perfectionistic Overcontroller mode, the client may come across as demanding and rigid. The therapist could inquire whether the tone or content of that message sounds like someone else—maybe the client's overbearing and critical father—and suggest placing the father in a chair. Alternatively, when a client comes into contact with her own vulnerability (e.g., her sense of defectiveness and shame), she may spontaneously associate it with the person who was the source of this shame (e.g., the ballet instructor who shamed her repeatedly).

Though empty-chair work is useful for facilitating both hurt *and* angry feelings, we should note that ST views the VC and the AC modes as requiring different therapist responses. Limited reparenting used with a VC is typically characterized by warmth, care, and nurturance. Empty-chair work with this mode primarily gives voice to the very fragile, hurt, and needy parts; through it, the client learns to recruit compassion, first and foremost from himself. In contrast, the therapeutic stance with the AC often requires a balance of validation and limit setting. If this mode is underregulated, the client may act out in rage and place himself and/or others at risk. If the mode is overregulated, the client loses out on the adaptive use of anger as a response to violations or boundary transgressions. Empty-chair work with this mode helps a client ventilate anger in safe and effective ways; through it, the client learns to assert himself, and establish safe and adaptive boundaries with other people.

Coda: The Integrated Self

We are often asked whether the emphasis on differentiating modes and responding to them differentially carries a risk of leading to a fragmented, nonunified self. The truth is quite the opposite. We see the distress that brings clients into therapy as a clear indication that their current self-organization is not working well for them. Typically, their coping modes are working overtime but do not fully block the negative messages of the Internalized Parental modes; the child modes do not receive adequate response, and the HA, if it exists at all, is fighting an uphill battle. By recognizing these modes and the ways in which they are at odds with each other, we try to help clients attain a better integration. The experiential, emotion-focused techniques outlined above, along with cognitive, behavioral, and relational techniques, are all embedded within a therapeutic relationship characterized by the ideal of limited reparenting. This package of interventions aims to strengthen the client's own HA mode, so that it provides the ultimate integration.

Giving Voice to the Integrated Self: Letter Writing

One last emotion-focused technique, *letter writing,* can aid in this integration process. In this technique, usually employed late in the therapy, clients are invited to write (though usually not send) a letter to their parents or other significant others who have hurt them when they were young. These letters help clients summarize what they had learned, and typically reflect many of the emotional insights gained in imagery and chairwork exercises, as well as the effects of the corrective emotional experience of the therapeutic relationship. Once written, the client is invited to read these aloud with the therapist, sometimes during a two-chair dialogue with the letter's addressee. The careful crafting of these letters (in or out of session) helps clients see the arc of the work they have done. It usually touches on the hurt itself, gives the clients a chance to voice their needs and assert their rights, and at times culminates with the modified view of the other (as guilty, damaged, limited; but at times, also as worthy of forgiveness or compassion). The subsequent reading of the letter in session is usually experienced as very cathartic, and gives the client and the therapist an opportunity to review and integrate many of the gains from the course of therapy.

Future Directions

The mode model includes both a theoretical developmental account and a pragmatic approach for addressing modes in the therapy. Above, we reviewed the growing evidence for the clinical utility of ST employing the mode model. In contrast, the empirical (and theoretical) foundation for the developmental account undergirding ST or the mode model is far from complete. We hope to see future work tackling this lacuna, and believe that it will further improve the treatment itself. For example, better understanding of the process through which internalized parental modes come into being may help resolve clinical dilemmas regarding the most appropriate course of intervention vis-à-vis these modes (i.e., outright confrontation vs. efforts at dialogical integration of these modes into the client's healthy adult).

Thus far, very little research that we are aware of has focused on process–outcome relationships. Such research is essential if we are to validate the proposed mechanisms of change in ST, and particularly the causal role of specific emotion-focused or experiential therapist interventions thought to facilitate change. We view this as a priority in future research on ST, and are actively pursuing such work ourselves. Such research would need to further validate the existence of schema modes (e.g., Shafran et al., 2014); to demonstrate the possibility of reliable in-session recognition of modes by trained clinicians; and to demonstrate whether specific

interventions aimed at specific modes lead to positive changes both within session and over the course of treatment.

The integrative nature of ST and its flexible framework are both strengths and potential limitations. The multiple toolboxes at the disposal of schema therapists reflect many influences and include varied techniques—emotion-focused, relational, cognitive, and behavioral. This plenitude may lead to substantial variability between therapists in the actual application of the approach: the same agreed-upon theoretical principles can lead to very different clinical choices by different therapists. We believe further research will lead to more detailed and nuanced models, which will improve our ability to approach particular clients (e.g., ones with a certain diagnosis or with certain characteristic needs or modes) with appropriate versions of the mode model, and with the specific interventions most likely to generate effective, efficient, and powerful change.

Further Resources

Articles/Chapters

- For a review of chairwork, see Kellogg (2004).
- For further reading on imagery and rescripting, see Holmes and Matthews (2010) and Arntz (Chapter 8, this volume).

Books

- See Young, Klosko, and Weishaar (2003) for a comprehensive practitioner's guide to ST.
- See Rafaeli, Bernstein, and Young (2011) for a more concise introduction to ST.
- See Arntz and van Genderen (2009) for the use of ST in treating BPD and Arntz and Jacob (2013) for broader guidance regarding mode work in ST.

Training Materials

- An American Psychological Association training video by Young is available at *www.apa.org/pubs/videos/4310804.aspx*.
- Videos illustrating specific ST techniques are available from *www.schematherapy.nl*.

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