Part I Overview of the Schema Therapy Model

Chapter 1

From Core Emotional Needs to Schemas, Coping Styles, and Schema Modes

The Conceptual Model of Schema Therapy

Introduction

In this chapter we provide a brief overview of the history of the development of schema therapy, and an overview of its model of the development of psychopathology and psychological health. This chapter will introduce the primary theoretical constructs of schema therapy – core emotional needs, early maladaptive schemas (EMS), coping styles, and schema modes – and explain how need deprivation gives rise to EMS, how coping styles interact with EMS to produce schema modes, and how these concepts produce psychopathology.

The Basic Schema Therapy Model

The Heart of Schema Therapy: Core Emotional Needs

It may be said that schema therapy could have very easily been named *needs therapy*, so central is the concept of *core emotional needs* to its practice. Although schema therapy began as an attempt by leading cognitive therapists to modify entrenched 'core beliefs' [1], schema therapy has evolved over the past three decades into a therapy whose central precept is the satisfaction of core emotional needs.

A core impetus for the development of schema therapy was Jeff Young and colleagues' observation in working with traditional cognitive therapy that, despite impressive outcomes in many clients, a substantial proportion (up to 50%) did not benefit significantly or enduringly [2]. Most of these cases appeared to have symptoms with clear links to childhood experiences and associated negative or traumatic memories. At the time, based on clinical observation, this group of therapists suspected that these 'schema patterns' reflected long-term 'characterological' issues with clear developmental antecedents.

Informed by the burgeoning developmental literature on psychological needs [4, 5, 6], and clinical observation, Young and colleagues described five core emotional needs that emerge in the developmental period. Understanding the extent to which these needs were met or unmet is pivotal to understanding chronic mental health problems [2]:

1. Secure attachments to others (includes safety, stability, nurturance, and acceptance).
2. Autonomy, competence, and sense of identity.
3. Freedom to express valid needs and emotions.
4. Spontaneity and play.
5. Realistic limits and self-control.

The heart of Young and colleagues' treatment model is that need satisfaction during childhood leads to the development of healthy schemas and related functional affective and behavioural patterns, while early need frustration leads directly to the development of EMS and related negative patterns of behaviour and maladaptive coping. The emphasis on early childhood development and the explicit causal role of unmet core emotional needs in producing EMS distinguished schema therapy from the prevailing theories of cognitive therapy at the time. Especially relevant types of early life experience were thought to be one or more of the following: (a) toxic frustration of needs; (b) exposure to overt trauma or victimisation; (c) a lack of boundaries or limits ('too much of a good thing'); and (d) selective internalisation or identification with significant others [2].

The Influence of Attachment Theory in Schema Therapy

Since their beginnings in the 1960s, theories of attachment [3] were quick to influence the hearts and minds of therapists in the field. The parallels between the experiences of clients' early patterns of attachment and their present-day problems appeared obvious. However, practical applications of this powerful new theory were lacking. Young was quick to recognise the importance of the theory for his emerging schema therapy model, integrating its emphasis on secure attachment as a core emotional need. Young acknowledged that the most important need for the developing child was the need for safe, stable, nurturing, and validating attachments. For Young, attachment to others was not a preference but a core emotional need, required for healthy development and well-being. To the degree that this need was thwarted during development, EMS would ensue. As noted earlier, children have a range of needs but, according to Young, attachment needs are of primary importance, laying the groundwork for other needs to be satisfied. The need for attachment and its relationship to a set of schemas in the Disconnection and Rejection domain is a primary focus for schema therapy interventions, especially *limited reparenting* interventions (see Chapter 6: Intervention Strategies for Schema Healing 1: Limited Reparenting for more detail). The original set of eighteen EMS – organised by their original domains and described in core belief terms – is described in Table 1.1.

Young's Schema Concept

Expanding upon earlier conceptions of schemas from authors such as Piaget [7], Young and colleagues [2] conceptualised schemas as a normal and central human phenomenon: an organising principle that enables humans to interpret and make sense of their experiences and the world. As children navigate and interpret the world, they will generally develop functional scripts, or schemas, which are representations of the world that are activated according to situational demands. Many schemas are mundane, representing what to expect (expectancies) or the kind of rules likely to be operating in one's environment, based on past experiences. In the broad field of cognitive psychology, schemas can be positive or negative, adaptive or maladaptive, and can be formed during childhood or later in life. Young's EMS refer to a core set of *problematic* schemas that tend to develop during childhood or adolescence, and which are centrally implicated in the development of various forms of psychopathology. For Young and colleagues [2], EMS can be defined as:

- a broad, pervasive theme or pattern
- comprised of memories, emotions, cognitions, and bodily sensations

Table 1.1 Schema domains and corresponding early maladaptive schemas*

Disconnection and Rejection Domain

1. ***Abandonment/Instability* (AB)**: Expectation that significant others will not be available to provide support, connection, strength, or protection.
2. ***Mistrust/Abuse* (MA)**: Expectation that others will hurt, abuse, humiliate, lie, cheat, steal, or manipulate.
3. ***Emotional Deprivation* (ED)**: Expectation that one will not receive adequate emotional support or be understood by others. Three major subtypes of deprivation include:
   (a) ***Deprivation of Nurturance***: The absence of attention, affection, warmth, and companionship – 'No one cares . . .'
   (b) ***Deprivation of Empathy***: The absence of understanding and attunement – 'No one really gets me . . .'
   (c) ***Deprivation of Protection***: The absence of direction, strength, and guidance – 'I am all alone (in facing the world)'.
4. ***Defectiveness/Shame* (DS)**: Belief that one is defective, unlovable, bad, unwanted, inferior, inadequate, and/or shameful.
5. ***Social Isolation/Alienation* (SI)**: Belief that one is socially isolated, different from others, and does not belong to any group or community.

Impaired Autonomy and Performance Domain

6. ***Dependence/Incompetence* (DI)**: Belief that one is helpless and unable to cope with everyday responsibilities without significant help from others, leading to lack of autonomy and self-reliance.
7. ***Vulnerability to Harm or Illness* (VH)**: Expectation that a catastrophe is imminent, and one will be unable to prevent it.
8. ***Enmeshment/Underdeveloped Self* (EM)**: Tendency to be overly emotionally involved with one or more significant others, resulting in impaired social development, inner direction, and individuation.
9. ***Failure* (FA)**: Belief that one has failed or will fail in areas of achievement and that one is incompetent, stupid, inept, untalented, etc.

Impaired Limits Domain

10. ***Entitlement/Grandiosity* (ET)**: Belief that one is superior to others, should receive special treatment, and should not be required to follow the same rules as others.
11. ***Insufficient Self-Control/Self-Discipline* (IS)**: Inability to appropriately restrain impulses and emotions; difficulty tolerating frustration and boredom to accomplish goals.

Other-Directedness Domain

12. ***Subjugation* (SB)**: Surrender of control to others and suppression of one's own emotions and needs to avoid anger, retaliation, or abandonment.
13. ***Self-Sacrifice* (SS)**: Hypersensitivity to emotional pain and suffering in others, and a tendency to take on responsibility for their needs and feelings at one's own expense.
14. ***Approval-Seeking/Recognition-Seeking* (AS)**: Excessive emphasis on gaining approval, recognition, or attention from others, resulting in an underdeveloped authentic sense of self. Often involves overemphasis on status, achievement, and/or money.

Table 1.1 (cont.)

Overvigilance and Inhibition Domain

15. ***Negativity/Pessimism* (NP)**: Exaggerated expectation that things will go wrong, or of making mistakes, leading to excessive worry. Focusing on the negative aspects of life and minimising positives.
16. ***Emotional Inhibition* (EI)**: Inhibiting spontaneous actions, feelings (especially anger), or communication to prevent being disapproved of, ridiculed, or losing control.
17. ***Unrelenting Standards/Hypercriticalness* (US)**: Belief that whatever one does is not good enough, that one must strive to meet very high standards of performance, usually to prevent criticism; and/or excessive emphasis on status, power at expense of health and happiness.
18. ***Punitiveness* (PU)**: Belief that people (self and others) should be severely punished for making mistakes or not meeting one's internalised expectations or standards.

* *Adapted from Young, Klosko, & Weishaar (2003)*

- regarding oneself and one's relationships with others
- developed during childhood or adolescence
- elaborated throughout one's lifetime, and
- dysfunctional to a significant degree.

EMS represent patterns of self-defeating affect and cognition that begin early in development and are repeated and elaborated throughout one's lifetime. They are triggered by current situations or circumstances relevant to the schema theme.

Key to this definition is the emphasis not only on cognitive content (e.g., core beliefs, negative automatic thoughts), but the interplay between all four components of EMS activation: (1) cognitive content; (2) memory/imagery – negative memories and imagery become more salient when the schema is triggered; (3) emotions; and (4) bodily sensations. Young and colleagues' definition highlights the significance of imagery-based, affective, and somatic processes in any approach to understanding and healing schemas. Young [2] argues that EMS are usually adaptive and accurate representations of the general tone of the family and childhood environment during the developmental period but may come to bias subsequent experience outside of that family context. EMS that were relatively accurate and perhaps adaptive during childhood can be maladaptive later in adult life. It is worth noting that in Young and colleagues' view of EMS, maladaptive coping behaviours are not themselves part of the EMS but are ways of coping with the EMS. These coping behaviours are said to be 'schema-driven' rather than representing a direct component of the schema per se.

Three Broad Maladaptive Coping Styles

Young argued that EMS are perpetuated through three broad styles of coping. Each represents a different type of adaptation to the EMS and functions to provide some sense of subjective relief from the emotions involved in the activation of the EMS. The coping behaviour usually blocks access to information that would otherwise disconfirm EMS-driven expectancies and maintains a longer-term disconnection from the satisfaction of

core emotional needs. This is how coping styles reinforce and maintain schemas (*schema perpetuation*). The three main coping styles are:

Schema Avoidance (Flight): Schema avoidance refers to coping by avoiding or escaping full activation of the EMS. Common examples include overt avoidance or escape from people, places, activities, or situations that could potentially trigger EMS, and actions that dull aversive emotional arousal, such as drug use or other compulsive behaviour, self-harm, and emotional detachment.

Schema Overcompensation (Fight): Schema overcompensation refers to a person responding to the threat of schema activation by 'fighting back' in some way against the core message of the EMS. This means thinking, acting, and feeling as though the opposite of the EMS is true. Recent authors have relabelled this coping style as *schema inversion* [6]. For example, someone with a Defectiveness/Shame EMS might overcompensate by displaying arrogance and acting as if they are better than others (i.e., the opposite of feeling less worthy).

Schema Surrender (Freeze): Schema surrendering involves resignation to the EMS – accepting its core message and acting as though it was true [8]. For example, someone with an Abandonment/Instability EMS might surrender by seeking out or committing to relationships that are not secure or stable (i.e., believing that no partner will ever provide them consistent, committed emotional and physical availability). Such clients may believe they 'should not expect any better'. Alternatively, they might surrender in a potentially healthy relationship by constantly seeking reassurance or checking up on their partner because they 'believe the schema' that tells them that 'their partner will leave them sooner or later', even in the absence of objective evidence.

The Schema Mode Model

Thus far we have described the first iteration of schema therapy, which has come to be known as the *basic schema therapy model*. Treatment with the basic schema therapy model emphasises focusing on changing EMS. However, in applying schema therapy to the most complex cases, involving personality disorders and serious and chronic mental health problems, Young recognised the need to modify and expand the model to account for the issue of multiplicity of self that is a common characteristic of these clients, especially those with borderline personality disorder (BPD) [2]. BPD clients often presented with what appeared to be various – often dissociated – 'parts' which had the quality of rapidly shifting mood states. BPD challenged the conceptualisation and treatment guided by the basic model. In response, Young and colleagues [2] offered a reformulated model – what has become known as the *schema mode model* – with schema modes as the central organising construct. This 'mode model' has become the dominant form of schema therapy and is the version of schema therapy that has garnered almost all of the available empirical support for schema therapy in clinical trials (see Chapter 2: Research Support for Schema Therapy).

Schema modes are defined by Young and colleagues [2] as 'those schemas or schema operations – adaptive or maladaptive – that are currently active for an individual' (p. 37). Modes are the state-like manifestation of the interaction between the person's currently activated EMS and their coping response at any given time. Personality is conceptualised as a group of distinct 'parts' with potentially separate affective, cognitive, behavioural, and motivational qualities. Young [2] initially presented four classes of modes: child modes, parent (critic) modes, coping modes, and the Healthy Adult mode. Research and theoretical development has since expanded the mode model [9, 10, 11, 12] to better account for a broader range of psychopathology. An up-to-date mode listing is given in Table 1.2. Our

Table 1.2 Schema modes

Child Modes

1. ***Vulnerable Child*** **(VCM)**: The Vulnerable Child mode is the 'storehouse' of EMS, whereby the person feels the emotions associated with EMS activation and unmet emotional needs but without the perspective of a Healthy Adult (e.g., a stable sense of self that transcends temporary emotional states, confidence in ability to cope). Typical emotions include feeling lonely, lost, frightened, frantic, sad, anxious, hurt, ashamed, and guilty. The core emotional 'flavour' of a Vulnerable Child mode varies according to the specific underlying EMS: for example, someone with an Emotional Deprivation EMS likely has a Lonely Child mode; someone with an Abandonment/Instability schema probably has an Abandoned Child mode; Dependence/Incompetence EMS manifests as a Dependent Child mode, and Mistrust/Abuse EMS as an Abused Child mode.

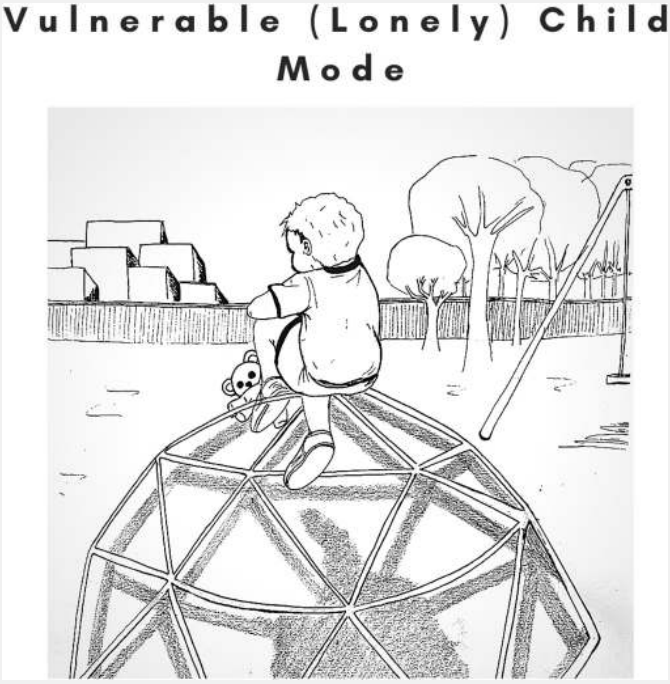

Illustration 1.1 'Vulnerable (Lonely) Child mode'

2. ***Angry Child*** **(ACM)**: Angry Child mode involves experiencing strong feelings of anger, rage, frustration, impatience, or indignation because core emotional or physical needs of the vulnerable child have not adequately been met. Anger is alternately suppressed and then expressed in inappropriate ways, such as through uncontrolled venting, without consideration of the consequences for themselves and others. The person may also act in a manner which is entitled or spoiled, expecting others to meet their needs immediately and perfectly, without consideration of others' needs or feelings.

Table 1.2 (cont.)

Illustration 1.2 'Angry Child mode'

3. ***Enraged Child*** **(ECM)**: Enraged Child mode involves experiencing extreme feelings of anger and fury, leading to destructive acts towards other people and/or objects. Others are seen as aggressors and anger is aimed at annihilating them either directly or indirectly. The person may scream, yell, and act in an uncontrolled way towards another. The tone is of a child who is enraged and has lost control.
4. ***Impulsive Child*** **(ICM)**: Impulsive Child mode responds to urges, impulses, cravings, and wants in the moment in an impulsive, uncontrolled way, without consideration of the medium- and longer-term impact on themselves or others. The person struggles to resist powerful desires and defer gratification. They may appear self-centred.
5. ***Undisciplined Child*** **(UCM)**: Undisciplined Child mode struggles to take responsibility and complete routine tasks. The person has difficulty tolerating the boredom or discomfort required to achieve longer-term goals.
6. ***Happy Child*** **(HCM)**: The person in Happy Child mode is contented, spontaneous, hopeful, calm, and embodied, due to having their core needs met. The person feels valued, cared for, understood, capable, effectual, energetic, motivated, playful, confident, protected, and safe. The person is flexible and able to adapt to the requirements of situations without compromising their own needs. They are emotionally and joyfully connected to others and to nature.

Coping Modes

Surrender Coping Modes (Resignation)

7. ***Compliant Surrenderer*** **(CSM)**: In Compliant Surrenderer mode the person is compliant, passive, submissive, pleasing, excessively agreeable, and allows others to take control in order to avoid conflict or criticism and/or to gain acceptance or nurturance. The person neglects their own needs so that they can prioritise the needs of others. They maintain a 'downtrodden' position through selecting relationships and/or behaving in a 'one-down' position.

Table 1.2 (cont.)

8. ***Helpless Surrenderer* (HSM)**: In Helpless Surrenderer mode the person feels helpless, impotent, dependent, ineffectual, passive, or stuck. They idealise others, perceiving them to be strong, competent, and potential rescuers, able to solve their difficulties. They may 'talk about' struggles and needs, but authentic connection to vulnerability is missing. The person in Helpless Surrenderer mode may have internalised the message that, to be worthy and deserving of care, they must demonstrate their needs through observable displays such as of helplessness, physical vulnerability, or frailty. The Helpless Surrenderer mode may be linked to 'learned helplessness' from childhood experiences that resulted in them feeling overpowered, helpless, overwhelmed, paralysed by fear of rejection, abandoned, or humiliated.
9. ***Self-Pity Victim* (SPVM)**: In Self-Pity Victim mode, the person sees themself as a victim. They perceive the world as unfair and feel that they have been uniquely singled out and persecuted. Others are perceived to hold power whilst they themselves are powerless. Therefore, they refuse to take responsibility for change.

Avoidance Coping Modes

10. ***Detached Protector* (DPM)**: The person in Detached Protector mode escapes from emotional suffering associated with schema activation through numbing, detachment, spacing-out, sleeping (excessive), dissociation, or somatisation. They may experience feelings of emptiness and boredom or depersonalisation. They may continue to cope with daily life in an apparently 'normal' or 'autopilot' way, whilst remaining emotionally distant from others.
11. ***Detached Self-Soother* (DSS)**: In Detached Self-Soother mode, the person escapes from overwhelming emotions through solitary activities designed to self-soothe, self-stimulate, or divert attention away from emotions. Coping behaviours frequently have an addictive or compulsive quality. Self-stimulation can include substance misuse, promiscuous sex, gambling, workaholism, extreme sports, online gaming, binge eating, alcoholism, online shopping, watching television (excessively), or fantasising.
12. ***Avoidant Protector* (AvPM)**: The person in Avoidant Protector mode attempts to prevent the risk of activating EMS through avoiding any overt situation (people, place, conversation, activity) which could potentially trigger vulnerable feelings.
13. ***Angry Protector* (APM)**: The Angry Protector mode protects the self via a wall of angry hostility, due to expecting that others will threaten, humiliate, or shame them if their underlying vulnerability is exposed. The anger is passive, but strategic, aimed at ensuring that others have no opportunity to hurt, reject, or exert power over them.

Overcompensation (Inversion) Modes

14. ***Approval/Recognition Seeker* (ASM)**: In the Approval/Recognition Seeker mode the person tries to impress others through ostentatious, flamboyant, or theatrical behaviours to overcome underlying loneliness or feeling 'unseen'.
15. ***Self-Aggrandiser* (SAM)**: The person in the Self-Aggrandiser mode seeks greater status, admiration, power, and control through behaving in a grandiose, entitled, abusive, or competitive manner. They devalue and diminish others in order to establish a 'one-up' position in relationships. The person in Self-Aggrandiser mode only values others insofar as they contribute to their status or glorify them in some way. The person believes themselves to be superior to others and expects to be treated as such. The person behaves in a self-absorbed way without consideration or empathy for others, and elevates their status through boasting, self-promotion, or humble-bragging.

Table 1.2 (cont.)

16. ***Overcontroller modes***: A person in one of the Overcontroller modes seeks to gain a sense of control through rumination, overanalysing, ritualised behaviour, overplanning, or obsessionality. The person may have a strong focus on productivity and time efficiency to attain a sense of achievement or worth and overcome an underlying sense of helplessness, impotence, or failure. People in Overcontroller modes attempt to reduce uncertainty, unpredictability, and vulnerability to potential harm through excessive attention to detail and adhering to rules in a rigid manner. There are several subtypes:
    a. ***Perfectionistic Overcontroller*** **(POCM)**: focuses on getting things 'right' and avoiding mistakes to minimise the possibility of criticism, disappointment, and failure.
    b. ***Suspicious Overcontroller*** **(SOCM)**: hypervigilant, wary, and suspicious of others' motives. The person may be controlling towards others to protect against a perceived threat and persecutory behaviour.
    c. ***Overanalysing Overcontroller*** **(OACM)**: characterised by the predominance of verbal-linguistic processing of past- and/or future-oriented material (e.g., rumination, worry, or obsessive thinking), at the expense of attending to the contextual and emotional qualities of present-moment experience.
    d. ****Scolding Overcontroller*** **(SOCM)**: attempts to control others through blaming, criticising, scolding, and/or presiding over them in an overbearing manner.
    e. ****Flagellating Overcontroller*** **(FOCM)**: overcompensates for fear of attack or punishment by punishing and blaming oneself, with the aim of restoring the illusion of control. Self-punishment or deprivation may also function as an attempt at self-improvement, to appease, to reduce the risk of being humiliated or punished (either by others or their own internal Critic), to increase predictability and perceived control over suffering and pain, or to atone for unresolved guilt or shame.
    f. ****Invincible/Hyperautonomous Overcontroller*** **(IOCM)**: feels invincible, indestructible, and powerful. The person seeks to be completely invulnerable and eliminate or be 'on top' of emotional needs by behaving in a manner which is self-sufficient and denies the need for emotional connection to others.
17. ***Bully and Attack*** **(BAM)**: In Bully and Attack mode, the person intimidates or attacks others strategically through threat or abusive acts (physical, sexual, emotional). The person attacks first to pre-empt attacks from others.
18. ***Conning and Manipulative*** **(CMM)**: In Conning and Manipulative mode, the person manipulates, cheats, deceives, or victimises others to achieve their own objectives, including exploitation or escaping consequences of their own actions.
19. ***Predator*** **(PM)**: The person in Predator mode plans and manoeuvres in a cold, calculating, and callous manner to eliminate others who represent a potential threat, enemy, competitor, or obstruction.

Maladaptive Inner Critic (Parent) Modes

20. ***Punitive Critic*** **(PuCrM)**: The Punitive Critic mode stores and replays internalised messages from childhood and adolescence that are harshly critical and punishing. This mode conveys the belief that vulnerability, needs, and emotions are signs of weakness and must be punished or eliminated. The person in the Punitive Critic mode may experience repeated re-enactment of previous experiences of self-blame, criticism, punishment, or deprivation.
21. ***Demanding Critic*** **(DeCrM)**: The Demanding Critic mode consists of the internalised voice that pushes, pressures, and prioritises achievement and high standards over health, well-being, and happiness. The person in Demanding Critic mode experiences thoughts containing black-and-white messages about the 'correct' way to behave through achieving the highest

Table 1.2 (cont.)

standards; being perfect, time efficient, and humble; devoting oneself to the needs of others; and retaining full control over the self and expression of emotions or needs.

22. ***Guilt-Inducing Critic* (GICr)**: The person in the Guilt-Inducing Critic mode experiences thoughts containing messages – received directly or implied, throughout their life – that others' needs are more important or urgent, and that the person is somehow a burden and undeserving of care. The person may also have internalised the message that the expression of their needs and emotions is selfish, potentially harmful or a threat to others and must be suppressed at all costs.

23. ***Healthy Adult (HAM)***: In the Healthy Adult mode, the person recognises, protects, and nurtures the inner Vulnerable Child and their needs, and demonstrates compassion for self and others. This mode demonstrates flexibility, seeking to balance prioritising the needs of self and others, and can manage adult responsibilities (sustaining a job, self-care, managing finances, caring for others). The Healthy Adult strives for a flexible balance between pleasant adult activities (intellectual/cultural/physical) and maintaining commitments. This mode experiences the body and mind as integrated aspects of the self, can give and receive nurturance and care, and gains meaning from authentic self-expression and connection with others and the world. This mode, when activated, can step back with awareness from one's automatic schema-based reactions and choose adaptive reactions with respect to one's longer-term needs.

**Proposed additional modes based on recent theoretical developments [8, 11, 12, 13]

approach to schema therapy assessment and case conceptualisation using the mode model is described in Chapter 3: Schema Therapy Assessment, and Chapter 4: Case Conceptualisation and Mode Mapping in Schema Therapy, respectively.

Schema Therapy Treatment Model

The schema therapy model was initially formulated as an alternative conceptualisation to the diagnostic categorisation approach (e.g., DSM5, ICD-11) to personality disorders. Young and colleagues argued that EMS lie at the heart of personality disturbance, and that the dysregulated behaviour captured by diagnostic labels such as 'borderline' and 'antisocial' are primarily *responses* to core EMS. Schema therapy has been demonstrated to successfully treat personality disorders and their traits by targeting EMS and their related coping styles or modes. Over the past twenty years, the schema therapy model has increasingly been applied to a broader range of psychological disorders, including chronic and treatment-resistant cases of those formerly known as DSM Axis I disorders. See Chapter 2: Research Support for Schema Therapy for an overview.

Mechanisms of Change (The Four Aims of Schema Therapy)

The schema therapy model suggests four related, but distinct mechanisms of change that become the central levers for schema therapy intervention:

1. **(Re)Connect to Core Emotional Needs.** Schema therapists aim to help clients experience increased satisfaction of their core emotional needs. Most clients referred for schema therapy have either disconnected from attending to their core emotional needs or have experienced chronic thwarting of need satisfaction during childhood and

adolescence. Schema therapists aim to 'kick start' or resume the client's emotional development by addressing those needs that were not adequately fulfilled in childhood and that are most connected to their set of current problems.

2. **Support Schema Healing.** Young and colleagues [2] argued that the ultimate goal of schema therapy is schema healing. Schema healing involves weakening all aspects of EMS: the intrusiveness and intensity of negative memories or images, the schema's emotional charge (including any bodily sensations), and maladaptive cognitions.
3. **Reverse Maladaptive Coping Responses.** Because maladaptive coping responses can maintain EMS and threaten long-term emotional need satisfaction, these behaviour patterns must be identified and replaced with more adaptive behavioural repertoires.
4. **Build the Healthy Adult Mode.** While schema healing and reversing maladaptive coping responses addresses deficits in personality functioning, schema therapy also aims to build positive capacities of personality functioning by 'building the Healthy Adult mode' [14, 15]. The client needs a strong Healthy Adult mode in order to take care of their emotional functioning when therapy finishes. Throughout therapy, schema therapists balance developing the Healthy Adult alongside schema healing tasks.

Four Broad Intervention Methods

1. **Therapy Relationship Strategies (Limited Reparenting)**: The foundation upon which change occurs in schema therapy is a strong *limited reparenting relationship*. In using limited reparenting strategies, the therapist aims to go beyond a 'standard' level of therapist care and warmth and makes attempts to directly meet the needs of clients, within the appropriate bounds of a therapy relationship. These strategies include providing not only care, attunement, and warmth, but also empathic confrontation and limit setting. These are discussed at length in Chapter 6: Intervention Strategies for Schema Healing 1: Limited Reparenting.
2. **Cognitive Techniques**: To the extent that clients are fused with EMS-driven beliefs, they will struggle to make significant change. Schema therapists initially help clients to challenge their negative and distorted schema-based view of themselves and the world, on a rational level. This will not necessarily lead to lasting emotional or behavioural change, but is often a necessary preparatory step to enable such change. An in-depth overview of cognitive strategies as they are applied in schema therapy is the focus of Chapter 7: Intervention Strategies for Schema Healing 2: Cognitive Strategies.
3. **Experiential Techniques**: Jeff Young and colleagues [2] and others [16] have argued that EMS are encoded on an emotional and implicational level and that, as such, strategies that are purely cognitive or 'cold' or logic-based are rarely enough to provide lasting change. The schema therapist provides opportunities for *corrective emotional experiences* that directly heal EMS on the emotional and implicational levels. We describe these 'experiential' strategies in depth in Chapter 8: Intervention Strategies for Schema Healing 3: Experiential Techniques.
4. **Behavioural Pattern-Breaking Techniques**: Perhaps the most important and, in some cases, time consuming aspects of schema change involves changing clients' maladaptive patterns of coping behaviour. Often significant work in the preceding techniques is required before large-scale changes can be made. Nonetheless, without changing maladaptive patterns of behaviour and learning more adaptive means to get needs met in

daily life, clients' schemas are unlikely to fully heal and remain vulnerable to relapse. Behavioural Pattern-Breaking strategies are the focus of Chapter 9: Intervention Strategies for Schema Healing 4: Behavioural Pattern-Breaking Techniques.

Six Flexible Developmental Treatment Phases

We have found it useful to think of schema therapy as a set of phases of change. Young originally conceived of two phases: (1) an assessment and education phase, and (2) a change phase. Other authors have proposed further stages that include periods where there is a distinct focus in the therapy on rapport building, safety and bonding, and the development of mode awareness [17]. Here we describe a set of phases the therapist might focus on as the therapy (and client) progresses. Generally speaking, the phases can be seen as sets of developmental tasks, in which each phase supports the growth and healing capacity of the client and is somewhat necessary for the next step. This is not meant to be a rigid set of steps. In practice, the focus of therapy might move back and forth between the steps depending on the client and the particular issues or challenges they are facing at that time.

1. ***Assessment and Education Phase.*** In this phase, the therapist conducts their schema and mode assessment (see Chapter 3: Schema Therapy Assessment) and starts the process of educating the client about their prominent modes and/or schemas and making links to their life patterns and current presenting issues. This culminates in attempts to convey the overall case conceptualisation and derive informed consent to start treatment in the change phase (i.e., focusing on steps 2–6). See Chapter 4: Case Conceptualisation and Mode Mapping in Schema Therapy for an overview of case conceptualisation and education using 'schema mode maps'.
2. ***Safety and Bonding.*** As the assessment unfolds and the client starts to view their experience in schema therapy terms, the schema therapist also works on bonding with the client and developing a strong limited reparenting relationship. In doing so, the therapist also looks for opportunities to help the client feel safe enough to be in therapy, addressing any therapy issues that come up early and, where possible, helping the client find the safety and stability in their life to make room for therapy and commit to change.
3. ***Schema/Mode Awareness.*** One of the initial goals of schema therapy is to help the client develop schema and mode awareness. Before clients can adequately benefit from phases 4–6, they must be able to understand their problems and understand the link between their life patterns and the underlying schemas and modes that underpin them.
4. ***Schema/Mode Management.*** As therapy progresses and the client develops an initial understanding of their problems, the schema therapist starts to help the client manage schema activation in their daily life. This often occurs through the use of behavioural pattern-breaking techniques and schema/mode flashcards.
5. ***Schema/Mode Healing.*** As clients attempt to change, they will invariably encounter having their schemas or modes triggered. The schema therapist uses sessions to work on healing schemas, particularly those which have been triggered during the previous week, usually with a focus on limited reparenting and experiential treatment strategies.
6. ***Autonomy Phase.*** Towards the end of treatment there is more of a focus on empowering the client to meet their own needs and activate their Healthy Adult mode to self-manage and overcome obstacles and challenges. In this stage, the therapist pushes more assertively for concrete behavioural change and prepares the client for eventual

termination of therapy (see Chapter 12: Preparing for Termination and the End Phase of Schema Therapy for more detail).

Recent Developments in the Model

The strong research focus within schema therapy means that the model is continuously undergoing development and refinement. Recently, some new and potentially important developments to the schema therapy model have been proposed by Arntz and colleagues [8]. Two additional core emotional needs have been proposed, building on the original five core needs: (1) The *need for Self-Coherence,* and (2) the *need for Fairness*. These two additional needs are, in turn, directly linked to three new EMS: (1) *Lack of a Coherent Identity* (2) *Lack of a Meaningful World*, and (3) *Unfairness*. Further, we have proposed an additional need for *Connectedness to Nature*, and an associated EMS, *Lack of Nature Connectedness* [18]. Whilst research is currently underway to verify the validity of these newly proposed needs and EMS, we have included descriptions of these in Chapter 3.

Arntz and colleagues [8] further propose that dysfunctional modes may be better understood as a combination of an activated EMS and coping. They propose that the term 'Surrender' be replaced with 'Resignation'. Resignation refers to the process whereby the person behaves as if the EMS were completely true, and the person 'acquiesces' to the assumptions and rules associated with the active EMS. This refinement of theory more explicitly states that Child and Critic modes reflect resignation to EMS. It is within these modes that the strongest EMS-associated affect is experienced and dominates the person's state of mind. Furthermore, all coping modes can be considered forms of either Avoidance or Inversion (formerly Compensation), in which the emotional suffering associated with specific EMS is either avoided or inverted. The two healthy functional modes described by Young, the Happy Child, and the Healthy Adult mode, remain within their current form.

Recent research [19, 20, 21, 22] also proposes new taxonomies of EMS which include EMS clusters rather than domains. In addition, new domains related to 'positive adaptive schemas' (PAS) have also been proposed and the reader is referred to the literature in this field [23]. The impact of this empirical work on EMS and PAS clusters on schema therapy practice has yet to be fully realised but will no doubt be of influence over time.

Concluding Remarks

Schema therapy aims to heal critical deficits in a client's developmental trajectory. The model guiding schema therapy can be daunting for therapists new to the approach, but it is enormously rich and can account for a comprehensive diversity of clinical presentations. We recommend that students of the approach take time to revise and familiarise themselves with concepts of core emotional needs, EMS, coping styles, and schema modes, as the quality of individual case formulation and treatment planning will depend on how attuned the therapist is to the presence of each of these in their clients. Self-help books by Young and Klosko [23], and Jacob, van Genderen and Seebauer [24] may be particularly helpful for therapists new to schema therapy and looking for elaborations of descriptions of schemas and modes. In the next chapter, we discuss in detail how to conduct clinical assessments of this critical theoretical information.

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