PSYCHOTERAPIA 1 (196) 2021
strony: 49–63
DOI: 10.12740/PT/134156

Maria Finogenow

EXPERIENTIAL TECHNIQUES AND THERAPEUTIC RELATIONSHIP IN SCHEMA THERAPY

University of Lodz, Institute of Psychology

therapeutic relationship
schema therapy
experiential techniques

Summary

Schema therapy has been elaborated by Jeffrey Young and his co-workers. It is derived from cognitive-behavioural therapy, yet it combines some elements of other concepts as well. Although it draws on a variety of classical cognitive and behavioural techniques, it strongly underlines the role of experiential techniques that are focused on emotions and the therapeutic relationship.

The techniques focused on emotions which are used in schema therapy are based on activating schema together with the linked cognitive functions, emotions, physical experiences, and recollections. The most important techniques in this group include Guided Imagery and Chair Work. Guided Imagery is used both in the assessment phase (to diagnose the schemas, their sources, style of coping, and modes) and in the treatment phase. The technique most often used in the latter phase is Imagery Rescripting, which is aimed at direct healing of a patient's schema. Chair Work is most frequently utilized to work with maladaptive coping modes.

In schema therapy, the therapeutic relationship plays a significant role both as a healing factor in the therapeutic process and also as an important background for the emotional interventions that are used. Two crucial characteristics of the therapeutic relationship are pointed out in this approach, namely Limited Reparenting and Empathic Confrontation.

Introduction

Schema therapy, developed by Jeffrey Young and his co-workers [1–3], originates from cognitive-behavioural therapy and it is included in the so-called "third wave" of cognitive-behavioural therapy. It is a relatively new integrative approach in psychotherapy and it combines also some elements of other concepts: attachment theory by Bowlby, transactional analysis by Berne, object relations theory, Gestalt, and person-focused concepts. It was started as a reaction to the lack of effectiveness of the classic cognitive-behavioural approach applied for patients who displayed chronic disorders and often some characteristics of personality disorders [3]. This approach is still developing and it awakes more and more interest in both psychotherapists and patients themselves.

The article is aimed at presenting schema therapy as an approach that originates from cognitive-behavioural therapy and also at underlining its distinctive character at the same time. Against a background of cognitive and behavioural techniques, there will be presented strategies which are most characteristic of this approach and which are to a large extent taken from other therapeutic approaches – experiential techniques and therapeutic relationship aspects.

The key notion in schema therapy relates to early maladaptive schemas. However, in Young and co-workers' [1–3] model, the schema notion from cognitive theories is broadened with some additional components [4]. According to the authors, schemas include not only their cognitive contents but also bodily sensations, emotions, and activities from those early situations, together with meanings that have been attributed to them. They contain our knowledge – in its broad sense – on ourselves, other people, and the world, and they function as filters which are used to organise, interpret, and predict the world [1–3, 5, 6]. In this way, schemas maintain themselves and become established, which does not allow for fulfilling basic needs also in adulthood [3, 6].

According to Young and co-workers [3], maladaptive schemas develop in an early stage of life as a result of interaction among a child's temperament, the parents' parental styles, and significant, sometimes traumatic, experiences. An important role in their development is played by the frustration of basic childhood needs, among which the authors count the need for secure attachment, autonomy and competence, acknowledgement of one's own feelings and needs, realistic limits, and also spontaneity and joy. These five major needs have been linked by the authors to 18 maladaptive schemas, such as Emotional Deprivation, Dependence/Incompetence, or Defectiveness/Shame [2, 3, 5]. According to the authors of the model, people cope with the schema-related emotions using three main styles of coping: schema avoidance (they try to avoid situations in which the truth of their schema contents could be verified), overcompensation (they behave contrary to their schema contents, trying to prove that the schema contents are false), and surrendering to a schema (they behave according to their schema contents, thus proving they are true) [1–3, 5, 6]. However, behaviours that are displayed within these three styles make it impossible to falsify the schemas. They lead to frustration of basic needs, interpersonal problems, increase in axis I symptoms, and following a vicious circle, they result in strengthening contents of the schemas.

The schema model described by Young and co-workers has appeared to have some limitations in clinical work with patients suffering from serious personality disorders [3], especially borderline personality disorder. Numerous schemas that are present in these patients, together with their tendency to change intensive emotional states rapidly, made it difficult to work using the original schema model. In order to render it possible to explain these rapid changes in the ways of thinking, feeling, and behaving, Young and co-workers have introduced the idea of s c h e m a m o d e s , called modes in short [2, 3, 5]. They are referred to as temporary emotional and cognitive states, which are also characterized by specific ways of coping. Modes determine the way in which a person perceives reality in a given moment, how they react to it, and what they predict in future.

At first, Young and co-workers [2, 3] distinguished 10 basic modes, which were classified into four categories: four Child Modes (Vulnerable Child, Angry Child, Impulsive and

Undisciplined Child, and Happy Child), among which only the last one is referred to as an adaptive mode, three Maladaptive Coping Modes (Detached Protector, Over-Compensator, Compliant Surrender), two Parent Modes (Punitive Parent and Demanding Parent), and the Healthy Adult Mode.

Among Child Modes, a particular significance in therapeutic work is attributed to the Vulnerable Child, as it reflects harms experienced by a patient in childhood. A patient in this mode feels painful emotions and is extremely vulnerable to hurt. Moreover, in this mode, contents from a majority of schemas are active. Maladaptive Coping Modes correspond to three styles of coping (schema avoidance, overcompensation, and surrendering to a schema). They reflect ways in which patients used to cope with their unfulfilled needs in their childhood. During that stage, these modes often played an adaptive role, yet in adulthood they have become a source of problems for a patient and they lead to further frustration of basic needs. Maladaptive Parent Modes in turn reflect ways in which parents (or some other important persons) used to treat a patient when he/she was a child. Patients in these modes are very critical of themselves, they want to punish themselves for their mistakes, or they put a lot of pressure on themselves to fulfil unrealistic demands. In order to present the three key notions of schema therapy (schemas, coping styles, and schema modes) and also mutual dependencies among them, there is shown in table 1 a case of a patient, with the description of one of her schemas, applied coping styles, and selected modes.

Table 1. **A case study**

Anna, aged 31, has come to therapy after parting with a partner with whom she had been in a relationship for two years. The patient's father left the family in her childhood, when Anna was hardly one year old, and then he did not maintain any relations with them. She was brought up mainly by her mother, who was working a lot and often went on business trips. Moreover, the patient's mother reacted to the patient in changeable ways. At times, she was very warm toward her, and then – often in a way that was not understandable to the child – she was angry at her, she reprimanded Anna for pestering her, and called her hopeless.
Abandonment/Instability schema is among the significant schemas of the patient. She is expecting continually that she will lose the closest persons, that she will be abandoned by them. She lives in constant fear and is alert to notice any signs that could suggest someone important for her will leave her. She had been avoiding the schema for many years. Although she is attractive and she was meeting with interest from men, Anna did not enter intimate relationships because of her fear of being harmed and wounded again. Two years ago she met Christopher, a man who was distanced and unapproachable, who lost his temper easily and then used to withdraw from the relation in silence. Thus, surrendering to the schema, the patient chose an inaccessible and unpredictable partner. In the course of the relationship, the patient was struggling against the schema. She was demanding constant attention from the partner and used to behave toward him in a possessive way.
These behaviours occurred in the patient almost every time when her partner displayed any signals of withdrawal or physical distance. In such situations the patient felt overwhelmed by fear that she would lose him, that he would leave her. While experiencing this fear, she was in the Vulnerable Child mode (specifically, in the Abandoned Child mode). Feeling this fear usually started the patient's mode of coping (Over-Compensator mode). The patient reacted by demanding confirmation of his feelings from the partner, she was checking his telephone and forbidding him to be away from home. When the partner started to be angry at her and to withdraw, the Punitive Parent mode was activating in the patient. While in this mode, she reprimanded herself saying she was hopeless and no one would put up with her anyway. This, in turn, often activated the Vulnerable Child mode, in which the patient felt overwhelming fear again.

table continued on the next page

In childhood, the Over-Compensator mode helped the patient cope with her fear of being left by her mother. However, in her adult life, the mode made the partner feel overwhelmed by the patient's behaviours, and thus he was distancing from her and protecting his privacy even more. Finally, the partner decided he would not stand such a relationship anymore and he broke off with her. In this way, the contents of the Abandoned schema in the patient were confirmed, thus consolidating her belief that persons important for her would always leave her.

As schema therapy was being developed, among others by teams supervised by Arnould Arntz and David P. Bernstein, the authors introduced and described some new modes [7–9]. There have been distinguished both more specific Child Modes, *e.g.* Defective Child, Abandoned Child, Inferior Child, and also numerous Coping Modes, *e.g.* Self-Aggrandizer, Over-Controller, Attention Seeker, which are assigned to the three major coping modes enumerated by Young and co-workers. At present, there are more than 20 modes described in the literature. They have been gathered and characterised in another work [10]. Furthermore, there have been elaborated mode models for particular personality disorders. These models contain modes that occur most frequently in patients with personality disorders, and it is on this basis that protocols of therapeutic work are written. The mode models for personality disorders from clusters B and C have been presented in another publication [10].

Therapeutic techniques in schema therapy

As schema therapy originates from the cognitive-behavioural approach, it applies both cognitive and behavioural interventions that are typical of this approach [3, 11]. Yet, an important difference consists in a great role given to emotion-focused experiential techniques and the significance of the therapeutic relationship in the healing process [2–4, 7, 12–14]. Therefore, the techniques used in schema therapy may be classified into four groups: cognitive, behavioural, experiential, and relational ones [3, 5, 7, 13, 14].

At the cognitive level, typical cognitive techniques are applied. For instance, some characteristics and origins of a given schema or mode are discussed, proofs for and against the truth of a schema are looked for, evidence confirming a schema is formulated anew, advantages and disadvantages related to former ways of coping (modes) are discussed, and reminding cards are prepared. The cognitive techniques are often introduced at the beginning of the change phase in therapy. With the therapist's help, the patient starts to build logical and rational arguments against a schema.

At the behavioural level, typical behavioural techniques are used which allow for reducing unhealthy behaviours that result from a schema and which help acquire new and healthy behaviours. They are usually applied at further stages of the therapy and are frequently preceded by emotional techniques. Although this aspect is sometimes referred to as a bit marginal, according to Young and co-workers [3], without changing former behavioural patterns, it is more than likely that the schemas become alive again despite having gone through them at cognitive and emotional levels.

At the emotional level, the main focus is on Child Modes and Maladaptive Parent Modes, as these are most strongly linked to intensive negative emotional states such as

self-hate, low self-esteem, the sense of being abandoned, lonely, guilty, ashamed, anxious, endangered, sad, disgusted, or angry. During emotional interventions, these emotions are first explained and transformed, and then restructured.

The therapeutic relationship plays a significant role both as a healing factor in the process of therapy and also as an important background for the emotional interventions that are used. The therapist is empathic, active, and open; he or she offers to start the relation as a real person. By means of Limited (corrective) Reparenting, the therapist attempts – in a limited scope – at fulfilling these needs of patients that were not fulfilled in their childhood. The therapeutic relationship plays also an important role during emotion-focused interventions – the therapist models adaptive and functional behaviours and feelings, takes care of the Child Modes, fights against the Punitive Parent in imagery techniques, and supports the use of new strategies in real life of the patient.

Experiential techniques

It is assumed in the classic cognitive-behavioural approach that early maladaptive schemas result mainly from disorders in thinking processes [4], and the basic technique of working with them lies in cognitive restructuring. Emotional components of schemas are given less weight. However, Young and co-workers [2, 3] have observed that cognitive techniques permit the patient to look at their schemas with reserve, yet despite using them, the patient may still experience overwhelming feelings related to the schemas and may still perceive them as real. For example, a patient may say 'Rationally I already *know* that I am not worthless, that this is not true. Yet I still *feel* that I am worthless.' This is consistent with research results which indicate that a change in cognitive functioning as a result of therapy does not always mean an improvement in emotional regulation [12].

Difficulties in modifying schemas by means of cognitive interventions only, and thus the need of using emotion-focused experiential techniques, result from the early period of forming most of the schemas and also from the very nature of traumatic experiences [15]. According to Young and co-workers [3], schemas are often started as a result of experiences from an early period of life, the one before speech development or the time when language is not a fully developed tool of cognitive operations yet. Most of these experiences become coded non-verbally as images or bodily and emotional sensations [15].

Similarly, some traumatic recollections are often deprived of verbal narration and context. They are also dependent on a situation/ a state, which means that they become activated when a person is in a similar situation or experiences a somatic state that is similar to the one in which a particular traumatic recollection appeared. Moreover, traumatic recollections are coded in a form of vivid sensations and images (independently from age) and it is difficult to measure them by means of linguistic meanings only. It is also difficult to assimilate or integrate them, which means that they are stored separately, they are isolated from our conscious attention and volitional control, and they remain unavailable in conditions that are not typical for them. Such recollections have also the tendency to stay in their original form and not to undergo any changes under the influence of time or later experiences [15].

Emotion-focused techniques that are applied in schema therapy are based upon activating schemas and the related thoughts, but also emotions, bodily sensations, and image recollections [2, 3]. Due to arousing emotions contained in schemas, the techniques become an effective way of changing non-verbal, emotional schema components. This has been confirmed by research results which prove that it is much easier to change schemas when thoughts related to them are 'heated up', which means they are activated together with the accompanying emotions [16].

The most important experiential techniques used in schema therapy include Imagery Work, especially Imagery Rescripting, and Chair Work [2, 3, 7, 12, 14].

Imagery Work

Imagery Work, proposed by Young and co-workers [2, 3], is a way of getting access to the Vulnerable Child mode. It allows the therapist for a more direct way of helping patients in coping with their painful emotions that have resulted from some difficult or traumatic events in childhood [2, 3, 5, 7, 12, 14]. It is the key technique that initiates experiencing schemas in therapy and it is widely used at later stages of the therapy, in the phase of schema modification, though its application may be also indispensable in the process of diagnosing.

In many cases, key schemas, styles of coping, and typical schema modes of the patient are well visible even during the initial sessions. However sometimes – especially in patients with dominant Detached Protector mode, which is characterized by avoiding affective experiences – there may appear some difficulties with identifying events that activate their schemas. That is why imagery exercises are used at the assessment phase in order to identify key schemas and their sources, styles of coping, and modes [3, 4, 14].

The technique which introduces a patient into Imagery Work is the one called Safe Place Imagery (imagining a safe place) [3, 7, 14]. This exercise may be used separately or as an introduction to further Imagery Work. Thanks to that the patient may immerse himself or herself in an image which encourages feeling calm. This image creates also a kind of a refuge, where the patient will be able to come back later, if experienced emotions are very strong. Next, the therapist may apply for instance Diagnostics Imagery Exercises. In this technique, the patient is asked to close his or her eyes and to let an image of a certain difficult experience from childhood appear. They are asked to visualize the image as precisely as possible and to tell what is going on in the image, using details as it was real at this moment. The therapist is asking questions regarding what the child (the patient as a child) is thinking about, feeling, and doing, and also what other persons in the imagined situations are doing (*e.g.*: parents, siblings, peers, teachers). Having passed through the diagnostic image, the therapist discusses its contents with the patient with regard to displayed needs, schemas, coping styles, or modes. The data gathered this way contribute greatly to forming a conceptualisation.

At the phase of schema modification, the technique of Imagery Rescripting is applied most often [2, 3, 7, 12, 14]. This technique was originally elaborated to heal victims of sexual abuse in childhood and it was aimed at reducing symptoms of PTSD and changing beliefs and schemas related to sexual abuse [15]. Next, it was adapted to work with varied traumatic and difficult childhood recollections [17–19] and also elaborated by Young and

co-workers [2, 3] to work with maladaptive schemas. Its application in schema therapy differs from imagery work that is used in other therapeutic methods. In schema therapy, it is stressed to provide a patient with some corrective emotional experiences that are intended to heal childhood traumas [2, 3, 7, 12, 14]. As compared to prolonged exposition [20], the schema therapist intervenes in a patient's image quite quickly, which protects the patient as a child (this process will be described later in the chapter), and as compared to EMDR [21], the therapist changes the scenario of traumatic events in a way which helps the patient fulfil his or her needs.

Similarly to the assessment phase, the technique of Imagery Rescripting is often started with imagining a secure place. It regards mainly work with traumatic recollections that are related to very strong emotions [14]. Next, the therapist asks the patient to recall an image of a difficult situation from his or her present life which also leads to strong and unpleasant emotions. When these emotions become intense, the therapist asks the patient to let the image from the present time flow away and then to allow for the appearance of the image from childhood in which he or she experienced negative emotions that are similar to the ones being experienced at present. After that the therapist (or another protective adult chosen by the patient) is introduced to the image of a traumatic situation and is looking after the child (the patient in his/her childhood) and helping him or her fulfil their needs.

In the course of imagining, traumatic or emotionally difficult experiences from the past are being changed in imagination so as to make needs of the Vulnerable (Abused, Abandoned, Defective) Child fulfilled. In practice, it may mean imagining stopping a perpetrator, taking the child from a place of a difficult event to another, secure place, and looking after the child. During Imagery Rescripting, negative emotions experienced by the child, *e.g.* anxiety, sadness, shame, are submitted to change due to an intervention made by the therapist (or another protective adult), who takes an active part in the imagined situation, protects the child and looks after his or her needs.

The fact that the child's needs are acknowledged and protected influences the patient in two ways. First, the patient becomes aware that he or she deserves acknowledgement and protection. Second, the experience of this healing feeling provides the patient with another perspective of the traumatic situation and a chance to experience it in a secure way. Furthermore, the patient starts to recognize his or her needs and discovers how to meet them. It is also very often the case that when patients come back to previous traumatic experiences in which they experienced emotions similar to those in present situations, they start to understand the meanings of emotions experienced in their current life.

The relation with the therapist and imagery modelling of a Healthy Adult mode by the therapist encourage forming and strengthening of the Healthy Adult mode in patients, who start to perceive their own needs and evaluate the world around them in a realistic way. Due to that, at further stages of the therapy it is possible to introduce the patient in the Healthy Adult mode into the imagined scene. As an adult, the patient protects his or her childish part, attends it with concern and care, and strives to fulfil the needs of the child.

The particular steps in the Imagery Rescripting may be presented in short as follows:

1. Relaxation and imagining a safe place
2. Recalling an image of a difficult situation from the presence

3. Building an emotional bridge of the difficult current situation
4. Recalling an image from the past related to similar emotions, with attention given to emotions and needs of the child
5. Introducing a person who will look after the child's needs (the therapist or a Healthy Adult) in such a way that the situation will be possible to change
6. Stabilizing the sense of security and positive secure attachment
7. Explaining a new emotional meaning of the traumatic situation from childhood.

However, this sequence is not an absolute rule and the technique may be applied in a flexible way [3, 7, 14]. In some cases, the sequence of images recalled by the patient starts with some upsetting images from childhood and only after them an unpleasant image from the present life is recalled [14]. It is also not possible to predict the precise contents and course of a given imagery exercise [3, 7]. The process of rescripting, *i.e.* creating a new scenario of a situation being recalled, should be always spontaneous and with the participation of the therapist and the patient. It demands a continuous attentiveness of the therapist and matching the intervention both to the patient's emotional state and to the needs that are being expressed [3, 7].

In the course of Imagery Rescripting, schemas and modes become activated together with accompanying negative emotions. These emotions are most often related to some traumatic recollections from an early stage of life of a patient [22] but sometimes, they regard recollections from school times as well. Thus, the technique may be used to write a new scenario of some traumatic events from a later period of life [3, 14]. Moreover, Imagery Work is utilized at times to prepare patients for some future events which arouse their strong emotions [23].

In the technique of Imagery Rescripting, it is not necessary to transform a negative image into a positive one so as to experience complete relief regarding the traumatic situation from childhood. It is important to change the previous "scenario", the course of events in previous traumatic situations into a more positive direction. This occurs to a large extent due to the protective, caring attitude of the therapist (or another adult), who provides the child with support and care in the image.

The goal of the technique is to make the patient feel the trauma-related emotions and needs which were not fulfilled then, and to change the meaning of the experienced trauma [2, 3, 7, 17–19]. The technique is intended to help the patient by means of offering a new and fresh perspective on situations that have occurred in the past and arousing new feelings that are not necessarily positive (for example, previous fear is replaced by anger at a person who used to harm the patient in the past). It is also to help in identifying needs and confronting the patient with the reality that happened so as to allow for a healthy mourning process.

Thus, on the one hand, the technique of Imagery Rescripting allows for cognitive restructuring, which occurs in a situation of strong emotional arousal. On the other hand, it makes it possible for a patient to experience a corrective, good relation with a protective adult who shelters and helps to fulfil the patient's emotional needs.

Chair Work

The technique of Chair Work has been borrowed by schema therapy from Gestalt therapy [24]; it is sometimes used also in some other therapeutic approaches, for example, in emotion-focused therapy [25]. It is a very flexible method [24]. The therapist may ask the patient to play varied roles, for instance, to present his or her different sides (in the case of schema therapy, these sides will be for example the patient's modes, which will be described in a further part of this chapter), parents, or other significant persons. In the course of an exercise, the therapist asks the patient to change roles several times and to carry on a dialogue among different persons. Also, the therapist may play a role and join the dialogue.

The most popular one among these techniques is the method of Two Chairs. First, a patient sits down on one chair and plays the first role (in schema therapy, it may be one of the patient's modes), then he or she moves to another chair and plays the second role. If more roles are played, more chairs are used. While sitting on one of the chairs, the patient tries to make their feelings, thoughts, recollections, and bodily sensations that are related to a given role as real and vivid as possible [24]. The role of the therapist is to conduct the whole scene, and sometimes to play one of the roles. The patient may be also asked to play the role of a therapist.

In schema therapy, the technique of Two Chairs may be applied to work on the patient's schemas – to have a dialogue with a schema. However, it is most often used to work with Maladaptive Coping Modes [2, 3, 5, 7, 12, 14]. While using two chairs, there is a dialogue situation arranged between a mode of coping and an external observer who is played by the therapist. The role of the observer is to make 'an interview' with a given mode, in the course of which there appear questions regarding the origins of the mode and its role in the patient's life to date. The patient sits down on the chair which is a symbol of the mode and is asked to enter thoroughly into a given perspective characteristic for the mode and to speak from this point of view only. The therapist addresses the patient by the name of the mode he or she is given, as if talking with a separate part of the patient's self.

As modes of coping usually developed in childhood and were playing an adaptive role at that time, the therapist stresses the importance of the mode in that period of life, acknowledges and appreciates it. On the other hand, as the patient's modes have become a source of suffering and numerous problems in adulthood, the therapist submits the mode to confrontation, stresses its negative influence on the patient's current life, and shows how the mode strengthens his or her negative schemas. While working with Anna, described in table 1, the therapist asked the patient to sit on an additional chair and feel there her Over-Compensator mode. Next, the therapist had a conversation with the patient (who was talking from the mode perspective) and the role of this mode in the patient's childhood was defined and acknowledged. While asking further questions, the therapist indicated how this mode used in the present life of the patient (including the relationship which had ended) had influenced her life and led to confirming her Abandonment schema.

The chair technique is also used in working with Parent Modes. In this case, the patient sits down on one of the chairs and portrays the mode of the Punitive or Demanding

Parent. Later, the patient learns to make boundaries to his or her punitive or over-demanding side, and at the same time, the Healthy Adult mode is being strengthened. During Chair Work, the patient manifests Child Modes as well. It is possible then to contact with their difficult emotions the source of which is in childhood. The therapist helps the patient to understand the source of the emotions and supports expressing feelings and needs in a healthy way.

Chair Work is aimed at helping the patient understand the role of a given maladaptive mode, to experience it, and then to modify it [2, 3, 7, 12, 14]. In Chair Work, the modes that were perceived earlier as egosyntonic (consistent with ego, accepted, desired) become more egodystonic (inconsistent with ego, undesired), which enables the patient to recognize them better in everyday life and to limit their impact upon their functioning [3, 12]. Moreover, on the one hand, Chair Work helps to differentiate modes, and on the other hand, it fosters internal integration [3, 12, 14]. For instance, a patient notices a relationship between the experienced strong emotions, such as the sense of guilt, sadness, shame, which are characteristic of the Vulnerable Child mode, and the activated Punitive Parent mode, which is an internalized voice of a parent who used to blame and punish him or her in childhood.

The last phase of Chair Work leads to strengthening the Healthy Adult mode in a patient, who should be able to stand up to Maladaptive Coping Modes and Maladaptive Parental Modes. Due to this mode, the patient becomes more capable of caring for the Vulnerable Child mode, and also supporting the Happy Child mode in expressing their needs and emotions.

Therapeutic Relationship

In schema therapy, the therapeutic relationship is referred to as an extremely important element of both diagnosis and schema change [2, 3, 5, 7, 11–14]. According to Young and co-workers [2, 3], there are two characteristics that play a significant role in the therapeutic relationship. These are: Limited Reparenting and Empathic Confrontation. They are often described as separate techniques, yet Young and co-workers [2, 3] underline that they are rather an attitude which is displayed by the therapist toward the patient during the whole process of therapy. This attitude requires building a sincere emotional bond with the patient and authentic concern about them.

Limited Reparenting refers to one of the basic assumptions of schema therapy in which it is claimed that early maladaptive schemas are formed as a result of frustration of basic emotional needs in childhood [2, 3, 7, 12–14]. That is why in the therapeutic relationship the therapist – to the extent limited by professional therapeutic relationship – behaves as ‘a good parent’ whose task it is to provide the child part of a patient with corrective emotional experiences. The therapist gives the patient – within a proper therapeutic relationship – what he or she needed to get from their parents but did not receive from them. The therapist offers the patient a similar version of emotional experiences that the patient lacked in childhood, and at the same time the therapist stays within boundaries set by ethical and professional rules.

Which needs will be fulfilled in a given therapeutic relationship is to a great extent dependent on schemas or modes which are most active in a particular patient [3, 5, 14]. For example, if a patient experienced emotional deprivation in childhood, the therapist focuses in therapy on giving attention and concern both during sessions and in the course of reconstructing recollections from childhood. If a patient has experienced limiting autonomy, the therapist supports his or her autonomous behaviours and encourages to make choices and decisions. If a patient is characterized by a schema of making claims, the therapist takes care of the vulnerable part of the patient and confronts and limits the claiming part.

Furthermore, another role of the therapist is to estimate which of the needs may be met by patients themselves and which demand some support from the therapist [14]. The therapist intervenes mainly when he or she notices needs that were not met in the patient's childhood and recognizes that without a therapeutic intervention they would probably remain still unfulfilled.

This means that using Limited Parenting requires the therapist to be very flexible and attentive to what is going on with the patient during a session. The use of this technique may vary depending both on the patient and also within a given therapeutic relationship on schemas that are activated at a moment or on dominant patient's modes.

The attitude in the therapeutic relationship that has been suggested by Young and his co-workers [2, 3] means that in many cases the therapist does not maintain neutrality and does not wait passively until patients abandon their harmful or risky behaviours themselves. The therapist helps to overcome problems and crises, offers support and advice, sets limits, and intervenes when the patient's behaviours are unfavourable. In the case of patients with borderline personality disorder, Young and co-workers [3, 13] additionally suggest making phone contacts beyond sessions possible and to provide the patient with flash-cards or other small things which may function as a symbol of the therapeutic bond.

As time passes, due to Limited Reparenting, the patient internalizes the warm and caring attitude of the therapist and includes it into his or her Healthy Adult mode. This enables the patient to become more and more compassionate and protective, to accept a strong affect better, to refrain from harmful behaviours, and to have more personal resources that help to cope in a healthy way. Furthermore, the patient learns to accept the therapist as a stable object and experiences secure attachment in this relationship [3, 5, 7, 12–14].

The second characteristic of the therapeutic relationship in schema therapy refers to Empathic Confrontation, which is also called empathic reality testing [3, 7, 12, 14]. It consists in simultaneous expression of empathy and concern for the patient and understanding reasons of his or her negative maladaptive behaviours together with confronting the patient with the necessity of changing these behaviours. During Empathetic Confrontation, the therapist does not judge a patient and does not attribute any immoral or unethical motives. Referring to the language of schemas and modes, the therapist points out frustrated needs which are a basis for maladaptive behaviours and emotions that are related to the Vulnerable Child mode, and at the same time, he or she underlines the need for change.

Empathic Confrontation may be applied both to the patient's maladaptive behaviours during a therapeutic session and to problematic behaviours in other life situations which

the patient talks about during a session. The use of the technique in order to confront behaviours that occur at session time is often extremely influential. It allows for precise examination of the patient's behaviours, schemas activated during a session, and accompanying emotions. In such a therapeutic relationship, the patient can discover directly how his or her behaviours influence other people. The therapist can refer to their own feelings and thus display in what way the patient's behaviour may make it harder to start close relations and meet relationship-related needs.

Empathic Confrontation renders it possible for the patient to understand the reasons for his or her own behaviours and also to understand and feel their negative consequences and the fact that they do not help to meet their needs. Thanks to this technique, patients often achieve a new look at their typical problem situations, they may perceive them in a more realistic and less schematic way.

Although the characteristics of the therapeutic relationship in schema therapy that have been discussed above are frequently presented as separate tools, they are not unconnected, self-sufficient therapeutic techniques [2, 3, 14]. They do not have a clear structure, they are used in a flexible way, and the therapist applies them fluidly in the course of the whole therapy. They are integrated with the remaining therapeutic interventions (cognitive, behavioural, and experiential ones).

Conclusions

Emotional interventions are aimed at overcoming Maladaptive Coping modes, explaining and transforming problematic negative emotions, changing a hidden and an overt meaning contained in schemas, and also strengthening positive emotions and experiencing secure attachment [2–4, 5, 7, 12, 14]. Moreover, these techniques help to circumvent one of the basic mechanisms of coping with unpleasant and painful feelings, namely avoiding them [26]. Although they may often arouse a strong unpleasant affect, especially during the first sessions with the use of imagery techniques, it is due to them that the patient may experience these emotions in a secure way, without being overwhelmed by them [27].

The use of experiential techniques requires a strong therapeutic alliance and trust between the patient and the therapist [3, 14, 28]. That is why the therapeutic relationship plays such a significant role in schema therapy. However, in this approach, the relationship is referred to as important also as a separate healing factor in the process of therapy. The relationship perceived this way demands high emotional engagement of the therapist. He or she often behaves like a real person, not an indifferent clinician in a doctor-patient relationship. Furthermore, it is necessary for the therapist to switch over continually between empathy and realistic situation assessment [3, 7, 12, 14]. The therapist perceives schemas and coping styles as comprehensible consequences of the patient's life history and at the same time, he or she directs attention to current negative consequences of the patient's behaviours.

Although schema therapy presents a relatively novel approach in psychotherapy, it becomes more and more common. Drawing from some previously elaborated therapeutic

models, it helps combine both work on early traumatic experiences (by means of offering corrective emotional experiences) and work on changing dysfunctional behaviours and relationship patterns in the present life of a patient. This is achieved due to experiential techniques and also on the basis of corrective experiences in the therapeutic relationship.

Moreover, schema therapy is an approach which is constantly developing. It has started as a response to some limitations of the classic cognitive-behavioural approach in treating patients with personality disorders, especially those with borderline personality disorder [1–3]. In the course of development of the approach, there have been written further protocols of work with patients suffering from varied personality disorders [7–10], and also from such chronic disorders as chronic depression [*e.g.* 29, 30] or eating disorders [*e.g.* 31]. Simultaneously, there have been conducted more and more empirical studies which verify both the model it is based on and the therapy's effectiveness [*e.g.* 32–34]. Being an integrative approach, schema therapy may be flexibly combined with other therapeutic procedures, for instance motivating dialogue, Acceptance and Commitment Therapy (ACT), or mindfulness-based cognitive therapy. This is consistent with the general trend in therapy development toward contextual perspective and work focused more on psychological processes.

References

1. Young JE. Cognitive therapy for personality disorders. A schema-focused approach Sarasota, FL: Professional Resources Press; 1990.
2. Young JE. Schema-focused therapy for personality disorders. In: Simos G, ed. Cognitive behaviour therapy: a guide for the practicing clinician. New York, London: Routledge, Taylor & Francis Group; 2002, vol.1, pp. 201–222.
3. Young JE, Klosko JS, Weishaar ME. Schema Therapy: A Practitioner's Guide. New York, NY: Guilford Press; 2003.
4. Bernstein DP. Schema therapy for personality disorders. In: Strack S, Eds. Handbook of personology and psychopathology. New Jersey: John Wiley & Sons, Inc; 2005, pp. 462–477.
5. Martin R, Young J. Schema therapy. In: Dobson KS, Eds. Handbook of cognitive-behavioral therapies. New York, London: The Guilford Press; 2010, pp. 317–346.
6. Young JE, Klosko JS. Reinventing your life: The Breakthrough Program to End Negative Behavior and Feel Great Again. New York: Plume; 1994.
7. Arntz A, Jacob B. Schema therapy in practice. Sussex: Wiley; 2012.
8. Bamelis LL, Renner F, Heidkamp D, Arntz A. Extended schema mode conceptualizations for specific personality disorders: an empirical study. J. Pers. Disord. 2011; 25(1): 41–58.
9. Bernstein DP, Arntz A, de Vos M. Schema focused therapy in forensic settings: theoretical model and recommendations for best clinical practice. Int. J. Forensic Ment. Health 2007; 6(2): 169–183.
10. Finogenow M. Tryby schematów i modele trybów w zaburzeniach osobowości z klastra B i C. (Schema Modes and Mode Models for Cluster B and C Personality Disorders). Psychoter. 2020; 1(192): 45–58. DOI: 10.12740/PT/118732.
11. Madej A. Techniki i metody poznawczo-behawioralne w terapii schematu zaburzeń osobowości. Psychoter. 2010; 1(152): 53–66.

12. Dadomo H, Grecucci A, Giardini I, Ugolini E, Carmelita A, Panzeri M. Schema therapy for emotional dysregulation: theoretical implication and clinical applications. Front. Psychol. 2016; 7: 1987. DOI: 10.3389/fpsyg.2016.01987.
13. Kellogg SH, Young JE. Schema therapy for borderline personality disorder. J. Clin. Psychol. 2006; 62(4): 445–458.
14. Rafaeli E, Bernstein DP, Young JE. Schema Therapy: Distinctive Features. New York: Routledge; 2011.
15. Smucker MR, Dancu C, Foa EB, Niederee JL. Imagery rescripting: A new treatment for survivors of childhood sexual abuse suffering from posttraumatic stress. J. Cogn. Psychother. 1995; 9: 3–3.
16. David D, Szentagotai A. Cognitions in cognitive-behavioral psychotherapies: Towards an integrative model. Clin. Psychol. Rev. 2006; 26: 284–298.
17. Arntz A. Imagery rescripting as a therapeutic technique: Review of clinical trials, basic studies, and research agenda. J. Exp. Psychopathol. 2012; 3: 189–208.
18. Arntz A, Weertman A. Treatment of childhood memories: theory and practice. Behav. Res. Ther. 1999; 37: 715–740.
19. Holmes EA, Arntz A, Smucker MR. Imagery rescripting in cognitive behaviour therapy: Images, treatment techniques and outcomes. J. Behav. Ther. Exp. Psychiatry 2007; 38(4): 297–305.
20. Foa EB, Hembree EA, Rothbaum BO. Prolonged exposure therapy for PTSD: Emotional reprocessing of traumatic experiences, therapist guide. New York: Oxford University Press; 2007.
21. Davidson PR, Parker KCH. Eye movement desensitization and reprocessing (EMDR): A meta-analysis. J. Consult. Clin. Psychol. 2001; 69: 305–316.
22. Marieke C, Abma TA, Bamelis L, Arntz A. Personality disorder patients' perspectives on the introduction of imagery within schema therapy: a qualitative study of patients' experiences. Cogn. Behav. Pract. 2011; 18: 482–490.
23. Hackmann A, Bennett-Levy J, Holmes EA. The Oxford guide to imagery in cognitive therapy. Oxford: Oxford University Press; 2011.
24. Kellogg S. Dialogical encounters: Contemporary perspectives on "chair-work" in psychotherapy. Psychother. Theor. Res. Pract. Train. 2004; 41: 310–320.
25. Greenberg LS, Watson JC. Emotion-focused therapy for depression. Washington, DC: American Psychological Association; 2006.
26. Borkovec TD, Alcaine OM, Behar E. Avoidance theory of worry and generalized anxiety disorder. In: Heinerg RG, Turk DS, Mennin DS, Eds. Generalized anxiety disorders: advances in research and practice. New York: Guilford Press; 2004, pp. 77–108.
27. Fassbinder E, Schweiger U, Martius D, Brand-de Wilde O, Arntz A. Emotion regulation in schema therapy and dialectical behavior therapy. Front. Psychol. 2016; 7: 1373. DOI: 10.3389/fpsyg.2016.01373.
28. Hoffart A, Oktedalen T, Langkaas TF, Wampold BE. Alliance and outcome in varying imagery procedures for PTSD: A study of within-person processes. J. Couns. Psychol. 2013; 60(4): 471–482.
29. Renner F, Arntz A, Leeuw I, Huibers M. Treatment for chronic depression using schema therapy. Clin Psychol, 2013; 20: 166–180.
30. Renner F, Arntz A, Peeters FPML, Lobbestael J, Huibers MJH. Schema therapy for chronic depression: Results of a multiple single case series. J. Behav. Ther. Exp. Psychiatry 2016; 51: 66–73.
31. Basile B, Tenore K, Mancini F. Early maladaptive schemas in overweight and obesity: A schema mode model. Heliyon 2019. DOI: 10.1016/j.heliyon.2019.e02361.

32. Lobbestael J, van Vreeswijk MF, Arntz A. An empirical test of schema mode conceptualizations in personality disorders. Behav. Res. Ther. 2008; 46: 854–860.
33. Mącik D. W pułapce schematów? Wczesne nieadaptacyjne schematy Jeffreya Younga a funkcjonowanie psychospołeczne osób dorosłych. Warszawa: Wydawnictwo Naukowe SCHOLAR; 2019.
34. Masley SA, Gillanders DT, Simpson SG, Taylor MA. A systematic review of the evidence base for schema therapy. Cogn. Behav. Ther. 2012; 41(3): 185–202.

E-mail address: mariafinogenow@op.pl