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ORIGINAL PAPER

Schema Therapy with Emotionally Inhibited and Fearful Patients

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Abstract
Emotional inhibition and avoidance are frequent problems in psychotherapy and often block the therapeutic process. Most often patients learnt these behavioral patterns early in childhood as coping strategies to protect themselves from painful emotions such as fear, sadness or shame. Schema therapy (ST) was specifically designed for patients with such rigid and hard to break through behavioral patterns and has shown to be a successful treatment for patients with cluster-C-personality disorders, which extensively display inhibited and fearful behavior. ST provides a set of techniques to address emotional inhibition and avoidance. The schema mode model helps patients to understand the origin and persistence of their problems and therapists can directly apply specific techniques for each mode. The therapist creates a caring, warm, parent-like relationship ('limited reparenting') and by this helps the patient to feel safer with emotions and with other people. Simultaneously, the therapist empathically confronts the patient with the problematic consequences of his behavior and pushes for change. Moreover, experiential techniques are frequently applied to help the patient experience and regulate emotions and needs in a safe way. By this, the patient loses fear of emotions, the meaning of emotions is changed and, thus, the patient can reduce using dysfunctional coping mechanisms. In this article, we describe the rational and the specific techniques of ST and illustrate them with a case example.

Keywords Schema therapy · Mode model · Emotional inhibition · Avoidance · Personality disorder

Introduction

Emotional inhibition and experiential avoidance are frequent problems in psychotherapy and often interfere with the therapeutic process. Emotional inhibition is defined by Young as 'the excessive inhibition of spontaneous action, feeling or communication-usually to avoid disapproval by others, feelings of shame, or losing control of one's impulses. The most common areas of inhibition involve: inhibition of anger and aggression, inhibition of positive impulses (e.g., joy, affection, sexual excitement, play), difficulty expressing vulnerability or communicating freely about one's feeling and needs, or excessive emphasis on rationality while disregarding emotions' (Young et al. 2003). Emotional inhibition is often connected with behavioral patterns of avoidance and/or over-control. Psychological mechanisms of over-control including perfectionism and emotional inhibition have been shown to be related to interpersonal problems and personality disorder (PD) symptom severity in many PDs and were identified as maintaining factors in PDs (Dimaggio et al. 2018). Experiential avoidance was first described by Steven Hayes and includes all efforts to control or avoid emotions, thoughts, images, memories or body sensations (Hayes et al. 2012) and can involve several strategies (e.g. passive resignation, distraction, suppression, obsessive compulsive behavior, substance abuse, dissociation, self-harm). Experiential avoidance has been shown to be a transdiagnostic risk factor for psychopathology (Aldao et al. 2010) and plays, together with bordering psychological constructs (i.e. rumination, worry, neuroticsm and anxiety sensitivity), an important role in the onset, relapse and maintenance of psychological disorders (Spinhoven et al. 2014, 2016, 2017). High levels of avoidance have been found to be associated with less improvement in treatment, while reduction of avoidance (and peak levels of processing) during the treatment process was associated with positive changes (Berking et al. 2009; Hayes et al. 2005). Thus, experiential avoidance

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might be an important target for psychotherapy. However, emotional inhibition and avoidance can be longstanding, very rigid behavioral patterns with an adaptive value (e.g., when emotional expression is dangerous and the situation cannot be changed) and a reinforcing effect (especially in the short run), and are often very hard to break through in psychotherapy.

Schema therapy (ST) (Young et al. 2003) was specifically designed for patients with such rigid and hard to break through dysfunctional behavioral patterns and has shown to be a successful treatment for patients with cluster-C-personality disorders, which extensively display emotional inhibited, over-controlling, avoiding and fearful behavior (Bamelis et al. 2013).

ST explains such behaviors from a developmental perspective and views them as coping strategies, which patients had to develop in response to adverse experiences in childhood: Most often the expression of emotions or needs was ignored, depreciated, or punished, thus patients learnt early in life to suppress and avoid emotions as an act of self-protection. Frustration of basic childhood needs such as safe attachment, love, affection or free expression of emotions and needs impairs the self-concept of the child, and as such, the child might view itself as unworthy, not loveable, defective, or as a failure. Avoidance or over-controlling behavior then might help to hide this 'shameful' side and protects the individual from being rejected or criticized. Adverse experiences with significant others also damage the trust in interpersonal relationships in general. As a consequence patients often feel unsafe in relationships. Thus, as a protection they try to keep others at a distance and do not share personal information or they show emotional inhibition and over-controlling behavior.

Distinctive Characteristics of ST

ST is an integrative method, which has its roots in CBT, but also draws ideas and techniques of other theoretical orientations (e.g. attachment theory, psychodynamic and experiential therapies). There are specific distinctive characteristics, which distinguish ST from CBT and other approaches: The *schema mode model* provides a clear structure to understand the origins and persistence of patients' problems. A strong emphasis is placed on *early development* with frustration of core emotional needs explaining the patients' problems in the here and now. The therapeutic relationship is conceptualized as 'Limited reparenting', which means that within professional boundaries ST therapists create an active, caring, parent-like relationship with the patient. This relationship serves as an antidote to adverse interpersonal experiences and helps the patient to feel safer with other people. Simultaneously therapists *empathically confront* patients with the problematic consequences of their behavior and the need for change. Moreover, *experiential techniques* are frequently applied to help the patient experience and process emotions in a safe way and to change the meaning of emotions, thus, patients can reduce their coping mechanisms and learn healthier schemas about themselves and their relationships with other people.

Early Maladaptive Schemas and Schema Modes

Central concepts in ST are *early maladaptive schemas* and *schema modes*. *Early maladaptive schemas* (EMS) are defined as dysfunctional knowledge structures acquired early in life that govern cognitive processes such as attention, interpretation or memory consolidation. EMS contain both explicit information such as dysfunctional beliefs as well as implicit knowledge, behavioral-procedural and emotional information (Jacob and Arntz 2013). *EMS* develop when core childhood needs are not adequately met. Activation of an EMS leads to distress; to deal with this distress coping strategies such as surrender, avoidance or overcompensation follow. A *schema mode* is a combination of activated schemas and coping strategies and describes the predominant emotional-cognitive-behavioral state at a given time point. It is therefore transient, while a schema is enduring (schema = trait, mode = state) (Young et al. 2003).

Schema modes are divided into four broad clusters: *Dysfunctional child modes* are associated with intense unpleasant emotions related to the activation of an EMS such as fear, loneliness, or sadness (vulnerable child modes), anger, or impulsivity (angry/impulsive child modes). *Dysfunctional parent modes* (punitive or demanding) are marked by self-devaluation, self-hatred, or extremely high standards and reflect negative internalizations about the self, which the patient has acquired in childhood due to the behavior of significant others (e.g. parents, teachers, peers). *Dysfunctional coping modes* are linked to the coping strategies surrender, avoidance, or overcompensation and serve as a protection for the child modes from further pain ('survival strategies'). Functional states encompass the *healthy adult* and the *happy child mode*.

For detailed description of EMS and modes we recommend the original manuals (Arntz and van Genderen 2009; Arntz and Jacob 2012; Young et al. 2003).

Case Conceptualization with the Schema Mode Model

At start of treatment with every patient an individual case conceptualization with the schema mode model is worked out. Most important symptoms, interpersonal and emotional problems of patients are conceptualized and put into context

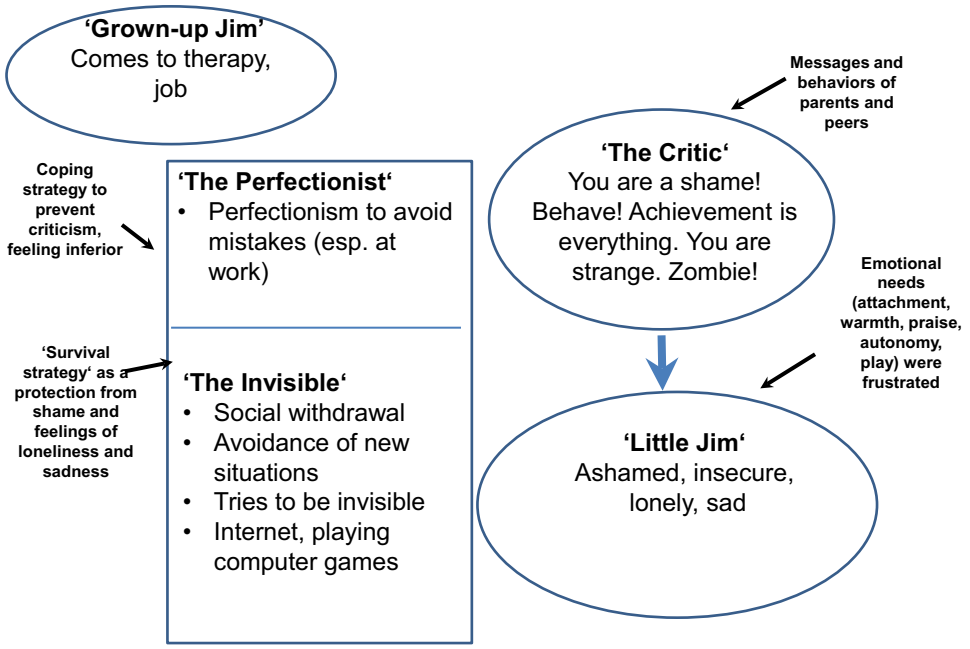

Fig. 1 Jim's mode model

with their developmental background. This helps patient to understand their problems and is most of the time very validating and relieving for them (De Klerk et al. 2017).

We illustrate how a case conceptualization is created with the case example of Jim,[1] a fearful, emotionally inhibited patient. Jim, a 52 year old IT-specialist, comes to treatment with chronic depression, avoidant PD and obsessive–compulsive traits. It soon becomes obvious, that Jim does not have many positive activities in his life. In his job he sits alone in his office and tries to fix pc problems for which he gets his orders by email. He does about two hours overtime every day to work through all orders. He does not have any social contacts ('I am not made for relationships. I just feel uncomfortable in contact with others. It always ends in a big shame for me.'). The only thing Jim likes is being in the internet and playing PC ('I guess it helps me to deal with the loneliness'). Both parents were teachers, achievement was very important in the family and especially at school his parents expected him to bring top marks. Everyday life was well planned and there was not much room for hobbies, friendship or play. Spontaneity, expression of emotions or needs was unwanted and even punished ('Stop laughing so loud. People are already looking at you as if you were an idiot'). Jim always felt like a failure, and was afraid to do something wrong. He tried to be silent, so that nobody would pay attention to him. In school the other pupils bullied him and called him 'zombie', since he was so silent and not looking at anyone.

Figure 1 shows Jim's mode model. Jim's vulnerable child mode ('Little Jim') is associated with shame, insecurity, fear to be not good enough and to be rejected as well as loneliness, and sadness. This mode developed since major childhood needs such as secure and warm attachment, acceptance, praise and play were frustrated. There are two dysfunctional parent modes reflecting the parents' behaviors and messages and the bullying of peers: a punitive parent mode, which is very critical and characterized by self-devaluating messages and a demanding parent which puts high demands and pressure on Jim to behave and do everything perfect, without mistake. To keep a better overview, the therapist decides to start to work with only one parent mode ('The Critic'), later in treatment he might divide the two modes, since they need different attention and therapeutic techniques. To deal with the circumstances in his childhood Jim developed two avoidant coping modes (an avoidant protector and a self soother mode) and an overcompensating coping mode ('perfectionistic overcontroller'). In the avoidant protector mode, which is typical for patients with avoidant PD, Jim tried to be invisible and behaved silent, so that no one would take a note of him. In this mode he avoids contacts with other people and new situations. In the Self Soother Mode Jim tries to soothe himself and to deal with the loneliness and sadness by surfing the internet and playing computer games. To keep the case conceptualization as simple as possible, the therapist merges these two avoidant coping modes into one ('The Invisible'). Jim also has a perfectionistic overcontroller mode ('the perfectionist'), which is the major coping mode in obsessive compulsive PD. This mode is almost only apparent at work, where Jim tries every day with overtime to fix all orders perfectly and very detailed to prevent

[1] The case of Jim does not describe a real patient. We constructed that case from our clinical experience.

criticism. 'Grown-up Jim' is the healthy adult mode and shows in Jim's job and that through all fears he has come to treatment. Typically for such emotionally inhibited patients in Jim's life there is not much space for the 'happy child mode' with happiness, joy and spontaneity.

A step-by-step guide how to perform a case formulation can be found elsewhere (Fassbinder et al., accepted).

Mode-Specific Aims of ST

The major aim of ST is to help patients get their frustrated needs better met and to change EMS. There are also specific aims for each group of modes: Dysfunctional child modes are supported and soothed. Dysfunctional parent modes are combated and reduced. Dysfunctional coping modes are validated as to their survival function, at the same time they are critically examined for their disadvantages. Patients are encouraged to reduce their coping modes and learn new healthier alternatives. The healthy adult mode and the happy child mode are strengthened. To achieve these goals ST uses the therapeutic relationship, as well as a set of experiential, cognitive and behavioral techniques. In the following we will explain how these techniques are employed for fearful, emotional inhibited patient and illustrate this with Jim's example. We focus on experiential techniques and the therapeutic relationship, because these techniques are extensively used and are best suitable to illustrate the distinctive features of ST. For a detail description of all techniques and a more comprehensive view where ST converges and diverges from other treatments we recommend reading these manuals (Arntz and van Genderen 2009; Arntz and Jacob 2012; Fassbinder and Arntz, accepted; Young et al. 2003; Fassbinder et al. 2016b). Further major aims in this group of patients are to help them to feel and express their emotions and needs, to get in social interaction with others, learning to open up and get close with others, to learn to deal with mistakes, to reduce shame and anxiety and to get more spontaneity, relaxation and fun in their lives.

Therapeutic Relationship

The central attitude of 'limited reparenting' means that the therapist behaves as if he/she were a good parent for the patient and fulfills the needs that where frustrated in childhood within appropriate boundaries of the therapy relationship. Frustration of basic childhood needs often happens in the nuclear family. This is why ST stresses the parental relationship, however traumatization of basic childhood needs of course can also be related to other relationships and experiences with significant others (e.g. being bullied in school or maltreated by a teacher or trainer). Limited reparenting serves as an antidote to all those traumatic experiences in childhood and is a source of corrective emotional experiences. Limited reparenting directly starts in the first treatment session. This is especially important for fearful, emotionally inhibited patients. The contact with a stranger, who will ask for your problems and inner experiences, is highly shame inducing, and thus leads to strong activation of coping modes. In case of an avoidant coping mode this might result in patients that seem distant and cannot name their problems or aims for psychotherapy. This often irritates psychotherapist and is sometimes misunderstood as low motivation. If patients feel misunderstood or rejected, shame and anxiety rise further and so does the coping mechanism, e.g. resulting in the patient shutting away even more and maybe not showing up for treatment anymore. In case of an overcompensating coping mode patients try to reduce shame and fear by being very controlled, strict and firm without showing any emotions or weaknesses. This makes it sometimes hard for therapists to see the suffering of the patient, keeps them like other people at a distance and sometimes, especially when the patient tries to control the therapist, feels unsympathetic. Limited reparenting helps in both variants, since therapists tailor their relational style to the specific needs of each patient. Not only patients profits from that central attitude, also therapists experience less irritation, anger and distress when confronted with strong coping modes. With the mode model in mind it is easier for them to see the vulnerable part and to understand these behaviors as 'survival strategies'. By this they can more genuine validate the patient, which makes patients feel better accepted and safer. Thus they can let go of their coping mode and open up better.

Like in real parenthood therapists adjust their relational style to patients' needs, skills and development or treatment phase. As such therapists are often very active and caring at the start of treatment, while with proceeding of treatment they step back and foster patients' autonomy and independence. Given the fact that ST is a time-limited therapy, this dynamic prevents patients from relieving abandonment experiences and prepares them for a live without treatment. It empowers patients and leads to growth of their healthy adult mode providing them with skills to deal with problems and emotions by their own and to build and maintain healthy relationship so that their needs are better fulfilled.

In Jim's example the therapist directly recognizes that Jim feels very uncomfortable. He sits in his chair very tensioned almost without movement, avoids eye contact, and answers as short as possible. Without knowing Jim's history the therapist assumes that he is very afraid to be rejected and that he needs safety, validation and encouragement. Thus, the therapist stays very friendly, empathetic and patient. She shows interest for Jim without putting pressure on him. She gives him time to answer, but also helps him to formulate his perceptions when pauses for answers are unpleasantly

long for him. Later in treatment when the therapist knows about John's development, EMSs, and modes, she adjust her therapeutic style even more to be an antidote to Jim's early experiences. As such she offers a very warm, caring and supportive relationship. She encourages him to express his emotions and needs. The therapist reinforces every little progress and helps with getting aware and formulating emotions and needs. The therapist herself opens up about her emotions (of course in a manner that is supportive for Jim), by this she models adequate expression of emotions, gives Jim feedback about the emotions he might activate in other persons and trains interpersonal skills, so that he feels safer with other people. The therapists includes humor and spontaneity in the treatment, e.g. by sometimes just doing something for fun (like reading a comic), so that Jim can learn that it is okay to relax and enjoy from time to time.

The second most important therapy relationship technique is *empathetic confrontation*: The therapist validates the patient's perceptions and behaviors, makes the connections between behavior, EMS, modes and childhood origin, while the therapist simultaneously confronts the patient with the consequences of this behavior and the need to change. Empathetic confrontation shows overlap with limited reparenting of course: Good parents besides providing safety, warmth and praise, also give clear, warm feedback if the child needs to change its behavior, set limits, encourage autonomy and growth.

In Jim's case the therapist empathically confronts Jim's avoidant protector mode: "Jim, I notice, that it is very hard for you to speak with me and tell me something about you. I think this is 'The Invisable', your protector mode, which tries to protect you from being ashamed or doing something wrong…and that is quite logical, that he does so, since there was a lot of pressure on little Jim, when you were young. The parents gave him the feeling he could not do anything right and in school he was bullied and 'the Invisible' helped him to get through all this…I am very grateful, he was there to help you…and he still protects you in social situations… At the same time 'The Invisible' also keeps me at a distance and I cannot see 'Little Jim', I cannot hear what he is thinking or feeling beyond shame and anxiety. I would like to get to know him a bit better and I guess he needs some support. What do you think about that?"

Experiential Technique

For fearful, emotionally inhibited patients experiential techniques are especially important since these patients are very cognitive and rational, and experiential techniques help them to get in contact with their emotions and needs. The step from thinking to experiencing and feeling is crucial for those patients, however fear of emotions is very high and often 'being emotionally' is seen as weakness and lack of self-control. Thus patients make every possible effort to avoid these techniques. Especially patients with overcompensating coping modes might devalue the techniques e.g. as being 'a waste of time' or 'ridiculous', which is often uncomfortable for therapists. It is important that therapists nevertheless stick to experiential techniques and keep on explaining why they are necessary and do empathetic confrontation to get the commitment of the patient for emotional work. To reduce resistance therapists should set up emotional work in small steps and give a lot of control and safety to patients, so that patients are not overwhelmed. Remarkably, although ST works intensively with experiential techniques, it is well accepted by patients and shows very low drop-out rates, even among cluster-C PD patients (Bamelis et al. 2013; De Klerk et al. 2017; Jacob and Arntz 2013).

Major techniques are imagery rescripting and chair dialogues. In *imagery rescripting* (Arntz and Weertman 1999) an adverse childhood memory related to the patients' EMS is imaged and the outcome is changed to a positive ending where the needs of the child are fulfilled. This is done by introducing a helping figure (e.g. the therapist, the patient's healthy adult mode or another supportive person or even a phantasy figure), who brings safety and cares for the other needs of the child. Aversive emotions such as fear, guilt, shame, feelings of incompetence are reduced, while positive emotional states such as secure attachment, being soothed and accepted, feeling competent, and happiness are fostered. For emotional inhibited patients it is crucial, that the helping figure helps the inhibited child to express its emotions and needs and confronts the parent that suppresses or punishes the child e.g. for being angry or having fun.

Jim and the therapist imaged the situations where Jim's mother said: 'Stop laughing so loud. People are already watching you. You sound like an idiot.' The therapist enters the scene and says to the mother: "Stop talking to your son like that. He hasn't done anything wrong. He is just laughing and having fun. That is good and totally normal for a boy. Nobody is looking at him as if he was an idiot. People enjoy that he is laughing, because everybody likes kids that have fun and knows that fun is good for children. It is just you thinking, that he needs to suppress his emotions. There must be some reason why you think that, maybe in your history. But no matter why, I can tell you, that it is not good for children and even not for adults to suppress their feelings. It makes them ill and depressive. They feel ashamed and uncomfortable with other people. Maybe you do not know this, but it is like poison for your son to suppress his joy." After the mother insists that Jim should not laugh but better do something useful, the therapist explains to Jim in a child-sensitive manner, that it is his mother having a problem and not him and that it is good to have fun and show emotions. The therapist asks him to tell her, what he is laughing about and he shows her a Garfield comic he got

from a boy in school. The Therapist and Jim then look together at the comic and laugh. The therapist asks about the boy in school also. Since Jim wants to be friends with him, but is also afraid that he might not like him, the therapist says: "I think chances are very good, that he likes you, because he gave you his Garfield comic. Maybe tomorrow you can tell him which comic you like best?"

In *chair dialogues* the different modes are 'placed' on different chairs and dialogues between them are performed. By this different perspectives and emotions can be expressed and processed. According to the mode-related goals (see above) therapists or the healthy adult adjusts the content of what they are saying, their tone of voice and their non-verbal behavior to the specific mode (e.g. they soothe the vulnerable child mode and fight the dysfunctional parent modes). The therapist can also model expression of emotions and needs, e.g. by taking place in the chair of the angry child mode and expressing disapproval or anger. This is an important technique especially for fearful, emotionally inhibited patients, since they did not have any models for adequate expression of emotions and vicarious learning often feels much safer for them in the beginning.

Cognitive Techniques

ST normally uses a broad range of cognitive techniques adapted to the frame of the mode-model and following the typical ST-goals, e.g. psychoeducation, pro-con lists, challenging beliefs, analysis of selective awareness processes, focusing on long term consequences, diaries, and flashcards.

In fearful, emotionally inhibited patients, cognitive techniques are not so much in the foreground and should be used with caution, since these patients are already very rational and tend to think too much. The most important cognitive techniques for those patients are psychoeducation on EMSs, modes, emotions, needs and normal development as well as weighing advantages and disadvantages of the coping modes. Also it is important to explain to patients that treatment does not aim at changing them to the other extreme and being emotionally and impulsive all the time. Therapy aims at a good balance of expression and control of emotions and needs, and at learning that if the expression has to be suppressed, that it is still okay and normal to have emotions and needs and that it is good to soothe and validate oneself and find the best possible solution in such a situation.

Behavioral Techniques

Behavioral techniques such as role play, behavioral experiments, homework, behavioral activation, problem solving or interpersonal skill training play an import role especially in the later stages of treatment. All techniques are adjusted to the mode model.

For fearful, emotionally inhibited patients it is essential that they learn to adjust their behaviors to their needs and values although this might cause unpleasant emotions such as fear or shame in the short run. A major focus is also to train to express their emotions to other people, especially positive emotions such as joy and affection as well as anger, and to be open to the emotions of other people without judging others as being weak or trying to avoid contact. This is first trained with the therapist in the safe atmosphere of the therapy relationship, later patients try the new behaviors with other people. This might be prepared with a role play (e.g. Jim prepared to tell his colleague that he likes his company and to ask him to go out for a beer and play chess). It is also very important to foster the happy child mode: After the imagery exercise the therapist asked Jim as homework to buy himself a Garfield comic and to read it just for fun. In another session she told him a joke and they watched funny videos on the internet. Jim got the homework to search for a good joke and tell it to the therapist next session. Then his homework was to tell the joke to three other people and see how they react. Often people with emotional inhibition do not really know what they like and enjoy, then the therapist helps them to find out and to experiment with new situations. For example, Jim went to a cooking course and at the end of the therapy he took part in a speed dating night, which was his idea since he wished to find a partner.

Recommendation of Further Reading and Summary of ST Outcome Research

For deeper understanding of the therapeutic techniques and more examples we recommend further reading of the original manual on ST (Young et al. 2003), detailed descriptions on work with the mode model in general (Arntz and Jacob 2012; Fassbinder and Arntz, accepted) and with patients with borderline PD (BPD) (Arntz and van Genderen 2009), and Cluster-C-PD (Arntz 2012). ST has proven its efficacy and effectiveness especially for the treatment of BPD with two randomized controlled trials (RCT) (Farrell et al. 2009; Giesen-Bloo et al. 2006), one case series (Nordahl and Nysaeter 2005), five open pilot studies and one implementation study (Dickhaut and Arntz 2013; Fassbinder et al. 2016a; Nadort et al. 2009; Reiss et al. 2013) demonstrating large improvements in reduction of all nine BPD symptoms, general psychiatric symptoms, and quality of life as well as low treatment drop out. Also for patients with other PDs with a majority of cluster C-PDs a randomized controlled trial demonstrated successful treatment with ST (Bamelis et al. 2013). The same study found ST to be cost-effective when compared to usual treatment for PDs (Bamelis et al. 2015). A study for ST in forensic patients will be published soon (Bernstein, personal communication). Positive results

were also found for ST in patients with depression (Carter et al. 2013; Malogiannis et al. 2014; Renner et al. 2016). Pilot studies document successful treatment with ST also for posttraumatic stress disorder, eating disorders and complex obsessive compulsive disorders (Cockram et al. 2010; Simpson et al. 2010; Thiel et al. 2016). Reviews summarize research findings on ST in general (Masley et al. 2012), in PDs (Jacob and Arntz 2013) and in borderline PD (Sempertegui et al. 2013).

It must be noted, that although ST provides specific techniques that target emotional inhibition and experiential avoidance and although these techniques are extremely likely to do so from clinical observation, research has not yet examined each of these techniques in their effectiveness in reducing emotional inhibition and experiential avoidance. For instance when looking at the main experiential techniques, the effectiveness of imagery rescripting has been amply demonstrated (Morina et al. 2017), whereas research into chair techniques is scarce.

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Compliance with Ethical Standards

Ethical Approval This article does not contain any studies with human participants or animals performed by any of the authors.

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