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CLINICAL CASE REPORT

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# Group schema therapy for patients with cluster-C personality disorders: A case study on avoidant personality disorder

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## Abstract

This article presents a clinical illustration of group schema therapy (GST) for cluster-C personality disorders (CL-C PDs) to provide therapists an example on how one can perform GST for CL-C PDs and break through persistent avoidance and control mechanisms. A summary of evidence supporting the effectiveness of GST for CL-C PD's is given followed by an overview of basic principles of schema therapy and GST. A case presentation next illustrates the application of GST principles and interventions in the GST CL-C protocol, which improve clients understanding of emotional core needs and development of adaptive ways of getting needs better met, instead of avoiding life. Implications of the case for future applications of GST for CL-C PDs are discussed.

**KEYWORDS**

avoidant personality disorder | cluster-C GST protocol, cluster-C personality disorder, group schema therapy, imagery rescripting, schema therapy

## 1 | INTRODUCTION

Cluster-C personality disorders (Cl-C PDs) are highly prevalent in general populations (3%–9%) and clinical populations (>20%; Hutsebaut et al., 2018). Cluster-C consists of three PDs: avoidant, dependent, and obsessive-compulsive. Patients with Cl-C PDs have high disease burden and societal costs (€48,000–79,000 per year per person in the Netherlands, 2015 prices). They also have major consequences for the prognosis of comorbid mental disorders; a major efficiency gain in health care can be achieved if Cl-C PDs are recognized and treated in time (Bamelis et al., 2015). Patients with CL-C PD present maladjusted personality traits and are often characterized by high levels of (social) anxiety. Avoidance and control are dominant coping strategies. CL-C patients often become

  

disturbed by their own social isolation, withdrawal, and inability to form close, interpersonal relationships and comorbid disorders such as mood, anxiety and addiction disorders. Treating CL-C patients can be challenging for therapists because it is difficult to break through persistent patterns of avoidance and control, and the tendency of CL-C patients to stick to a passive patient role. Moreover, CL-C PD patients' avoidance tends to be pervasive and does not only concern avoidance in the social sphere, but also avoidance of decision making, experiencing negative and positive emotions, sharing intimate feelings, experiencing bodily sensations, experiencing sexual arousal, eating flavored and spicy food, and engaging in potentially risky activities (Arntz, 2012). Schema therapy (ST) provides a theoretical framework and specific mode models for Cluster C PDs, which make patients' complex problems relatively easily understandable in terms of schema modes. This gives therapists the possibility to detect which mode is active during a session and apply techniques specifically developed for each one (Arntz, 2012).

To date, international guidelines for treatment of Cl-C PDs are nonexistent, mostly due to the fact that research on cost-effectiveness of the treatment of Cl-C PDs is very scarce. The only controlled cost-effectiveness study published so far found individual schema therapy (IST) superior to treatment as usual (TAU; Bamelis et al., 2015). Group treatment is an attractive solution for improving quality and efficiency of health care as larger numbers can be treated in (>50%) less time compared to individual therapy. Especially because research suggests that group therapy is similarly effective as individual therapy. Several meta-analyses have found no difference between effectiveness of the two modalities for several theoretical orientations and across various disorders such as anxiety and mood disorders and PDs (mostly borderline PD; Burlingame & Jensen, 2017). After a systematic literature review (PsycINFO and Medline) on CL-C PDs and RCT we concluded that a meta-analysis on group therapy for Cl-C PDs could not be performed due to a lack of adequately powered RCTs on group therapy for Cl-C. Only two adequately powered RCTs of treatment of Cl-C PDs were found (Bamelis, 2014, 2015; Balje 2016). These support IST as treatment of Cl-C PDs and preliminary GST as treatment of social anxiety disorder with comorbid avoidant PD. No RCT into GST for Cl-C PDs was found. There is a need for adequately powered RCT's into effectiveness of group therapy for Cl-C PDs.

Group schema therapy (GST) for PDs is becoming increasingly popular in clinical practice. Whilst there is evidence for its effectiveness for Borderline PD (Farrell et al., 2009), a large group of patients currently receiving GST has a Cluster-C PD as primary diagnosis. Although individual ST for these patients has a solid empirical base as to effectiveness, cost-effectiveness, and treatment retention (Bamelis et al., 2015), the evidence for the Farrell & Shaw GST model as a treatment for cluster-C PDs is limited to a small Australian pilot study (Skewes et al., 2015), clinical impression, and preliminary observations of a running RCT comparing GST to group-cognitive behavioral therapy (CBT) for the double diagnosis of avoidant PD and Social Anxiety Disorder (Baljé et al., 2016).

There also is the problem that various variations of GST are applied under the same (GST) label, which creates a barrier for quality maintenance and training of new therapist: what exactly is the protocol that should be used? Recently, a protocol for GST for CL-C has been formulated, which facilitates training and implementation, making it easily accessible for large patients groups. A multicenter pilot study tested the effectiveness of this protocol with appropriate outcome measures (such as severity of manifestations of the primary PD, general psychological symptoms, self-esteem, and social and societal functioning). Preliminary results show promising results, low dropout rates and large effect sizes (Arntz et al., 2021). As a next step, a large ($n = 380$) multicenter cost-effectiveness RCT with three arms (IST, GST, and TAU) will investigate cost-effectiveness and patient characteristics that predict the best response in these arms (Arntz & Bachrach, 2020).

This case report is aimed at presenting a case illustration of the protocol for GST for CL-C PD's to provide therapists an example on how one can perform GST for CL-C PD's and break through persistent avoidance and control mechanisms. The specific case of Jim was selected because of the fact that his main diagnosis was avoidant PD, as social avoidance is the theme of this special issue, and because Jim's case is illustrative of the long road CL-PD patients often complete before there are able to lead a fulfilling life.

GST might deliver a cost-effective solution for unnecessary long treatments and chronicity of Cl-C PDs. There is a great need for efficient and effective treatments for PDs: waitlists for specialized PD-treatments are long (NZA, 2019)

and many patients with PDs do not receive adequate (evidence based) treatment for PD (Bamelis et al., 2014). Before illustrating the case example of GST for CL-C, the basic principles of ST and GST will be discussed.

## 2 | SCHEMA THERAPY

ST is developed by Jeffrey Young and has its roots in CBT (Young et al., 2003). ST also incorporates several techniques and concepts of other theoretical orientations (e.g., attachment theory, psychodynamic, and experiential therapies). In addition to cognitive and behavior-oriented techniques, ST extensively uses experiential techniques. The therapeutic relationship is conceptualized as "limited reparenting" meaning that the therapist—within the boundaries of a professional therapy relationship- behaves like a "good parent" towards the patient.

In ST it is assumed that traumatization in childhood and frustration of basic childhood needs in interaction with biological and cultural factors lead to the development of early maladaptive schemas (basic mental representations of the self, the relationship to others and the world) and dysfunctional schema modes (emotional-cognitive-behavioral states). This assumption is supported by several research findings showing a strong relationship between the development of maladaptive schemas and negative childhood experiences, and mediation of the relationship between childhood experiences and PDs by schemas (Carr & Francis, 2010). The major goal in ST is helping patients to understand their emotional core needs and learn adaptive ways of getting basic emotional needs met, such as secure attachment to others, autonomy, competence, and sense of identity, freedom to express valid needs and emotion, spontaneity and play and realistic limits and self-control (Fassbinder & Arntz, 2019). This requires breaking through long-standing emotional, cognitive and behavioral patterns, meaning change of dysfunctional schemas, coping strategies and schema modes.

## 3 | MALADAPTIVE SCHEMA'S

In ST it is assumed that maladaptive schema and schema modes cause psychological problems in adult life. Schemas are developed during childhood or adolescence and elaborated throughout one's lifetime. Early maladaptive schemas are broad pervasive life themes or patterns of information processing compromised of memories, emotions, cognitions, bodily sensations and attention preferences (Young et al., 2003). Schemas contain both implicit and nonverbal knowledge and explicit and verbal knowledge accessible to consciousness. They have a self-sustaining character, since information is processed in a way that fits the schema (Fassbinder et al., 2020). Internal or external triggers activate early maladaptive schemas. Activation of the maladaptive schema usually leads to psychological distress and painful emotions. To deal with this individuals use coping strategies; which can be categorized in three types: Surrender (giving in to one's schema); Avoidance (avoiding full activation and awareness of one's schemas), Overcompensation (fighting one's schema by believing and doing the opposite of the schema).

Young et al. (2003) described 18 maladaptive schemas, divided in five domains. Each domain is related to a category of basic needs (see Table 1). Several psychometric studies investigating the psychometric properties of the Young Schema Questionnaire (YSQ) have found a stable factor structure in clinical samples (Baranoff et al., 2006; Calvete et al., 2013; Rijkeboer & van den Berg, 2006).

## 4 | SCHEMA MODES

Patients with severe personality pathology often have many maladaptive schemas and they use different maladaptive coping strategies to deal with these schemas. This leads to multitude of possible combinations and therefore a high level of complexity for both patient and therapist. Furthermore the schema concept does not

**TABLE 1** Early maladaptive schemas and schema domains after Young et al. (2003)

| |
|---|
| Disconnection and rejection |
| • Abandonment/instability<br>• Mistrust/abuse<br>• deprivation<br>• Defectiveness/shame<br>• Social isolation/alienation |
| Impaired autonomy and achievement |
| • Dependency/incompetence<br>• Vulnerability to harm and illness<br>• Enmeshment/undeveloped self<br>• Failure |
| Impaired limits |
| • Entitlement/grandiosity<br>• Insufficient self-control |
| Other-directedness |
| • Subjugation<br>• Self sacrifice<br>• Approval seeking |
| Overvigilance and inhibition |
| • Negativity/pessimism<br>• Emotional inhibition<br>• Unrelenting standards<br>• Punitiveness |

explain the quick mood and behavior changes of patients (Fassbinder et al., 2020). Young (2003), therefore, extended the schema theory with the mode model approach. A schema mode is a combination of an activated schema and a coping strategy, and describes the emotional-cognitive-behavioral state of a patient, which is active at a given moment in time. In clinical practice a case formulation is made by creating a mode model together with the patient, based on the results of schema mode inventory (SMI), YSQ, and idiosyncratic information of the patient. In the basic mode-model there are four broad categories of modes.

## 4.1 | Dysfunctional child modes

In these modes patients experience intense aversive emotions, for example, fear of abandonment, loneliness, helplessness, sadness, or mistrust (vulnerable child modes), but also anger, rage, impulsivity, or lack of discipline (angry/enraged/impulsive/undisciplined child modes).

## 4.2 | Dysfunctional parent modes

Dysfunctional parent modes (punitive, demanding) are characterized by internalized negative beliefs about the self, which the patient has acquired in childhood due to the behavior and reactions of significant others (e.g., parents, teachers, peers). They are associated with self-devaluation, feelings of self-hatred, guilt, shame or extremely high standards.

### 4.3 | Dysfunctional coping modes

Dysfunctional coping modes serve to reduce the emotional pain and distress of child and parent modes and describe the excessive use of the coping strategies avoidance, or overcompensation. These modes are usually acquired early in childhood to protect the child from further harm and are therefore considered as "survival strategies."

### 4.4 | Healthy modes

The healthy modes of the healthy adult mode and the happy child mode represent functional states. In the healthy adult mode, people can deal with emotions, care for their needs, assert themselves in a functional way, solve problems and create healthy relationship. The happy child mode is associated with joy, fun, play, and spontaneity.

## 5 | GROUP SCHEMA THERAPY

GST is an integrative form of group therapy, which combines aspects of directive group therapy with aspects of psychodynamic groups and has a unique way of handling the group dynamics. Two therapists who adopt a parental role lead the group. The therapists work together as good "parents." This means that they try to balance individual needs and collective needs of the group like parents handle siblings in a family. They attempt to connect with every patient. They have a quiet, friendly, clear way of talking. This comforts the patients and creates a friendly atmosphere within the group. Being a good parenting couple also means that the therapists take turns leading the group process; therefore the roles of therapist and co-therapist change regularly. When one therapist focuses his attention on one of the group members, the other therapist ensures that the rest of the group remains engaged (both verbally and nonverbally; Arntz & van Genderen, 2020, chapter 10).

Group therapy has several advantages over individual therapy such as: mutual support, trust and appreciation between group members; more opportunities to experiment with expressing emotions and new behaviors.; emphatic confrontation by group members in response to undesirable behavior might be more effective than confrontation by a therapist (Arntz & van Genderen, 2020).

## 6 | GST TECHNIQUES

All ST techniques can be applied in a group setting. However, some adjustments are made. Because every patient needs to be addressed during group sessions, it is customary not to work too long with a single patient. Techniques are often applied in an abbreviated form or are regularly interrupted so that experiences can be shared with the rest of the group. All patients are stimulated as much as possible to join in during the exercises (Arntz & Genderen, 2020; Farrell & Shaw, 2012).

### 6.1 | Imagery rescripting

Each group member learns to create his or her own safe place. The therapists can help by suggesting a specific safe place or safety bubble. Once a safe haven has been found, the therapists ask patients to imagine that they're a small child for a couple of moments, to make contact with the abandoned child. Therapists stimulate group members to think of as many ways as possible in which the need of the child can be met and allow all the group

members to help with rescripting. In a later stage of the therapy, group imagery rescripting is performed regularly, by rescripting a single patient's memory or simultaneous rescripting the memories of all group members (Arntz & Genderen, 2020; Farrell & Shaw, 2012). Imagery rescripting aims to emotionally process and correct dysfunctional meanings of childhood memories.

### 6.2 | Role-play

When performing role-play in the present or the past, as many group members as possible are used to play various roles. When using role-play for current or future situations, group members can assist in thinking of and demonstrating various reactions. For historical role-play, the advantage is that complex situations from the past can be simulated with multiple participants filling the various roles. Role-play aims to emotionally process and correct dysfunctional meanings of childhood memories. (Arntz & Genderen, 2020; Farrell & Shaw, 2012).

### 6.3 | Two-or-more-chair technique

With the two-or-more-chair technique in a group setting, there is no empty chair; an object can be placed on the chair, which represents the mode that needs to be worked on, or one of the therapists or other patients plays the mode. For instance a representation of the punitive parent can be draped over the chair so that the entire group can focus on the doll. The doll can then be thrown away or stuffed in a closet to symbolize that he is gone and needs to stay gone. One therapist can sit in the punitive parent chair the other therapist can then combat him (together with as many patients as possible) and stand up for the rights of the abandoned/abused child.

Through this technique, the patient will feel protected against these modes and supported in the right to make mistakes, to have needs and emotions, and to express opinions (Arntz & Genderen, 2020; Farrell & Shaw, 2012).

### 6.4 | Cognitive and behavioral techniques

Cognitive techniques are more readily applied in group therapy than in individual therapy because patients have less trouble identifying the healthy adult with regards to another group member than they do with their own healthy adult. Behavioral techniques can similarly be applied more readily because there are many more possibilities to practice with multiple people within a safe environment. Psychoeducation is the most often used cognitive technique. Instead of challenging possible misinterpretations, therapists more often rely on educating the patient about normal emotional needs and the function of emotions, as most patients lack healthy knowledge in these areas (Arntz & Genderen, 2020; Farrell & Shaw, 2012).

## 7 | GST FOR CL-C PDS

GST for Cl-C PDs consists of 30 sessions and 4 booster sessions in small groups, with an additional maximum of 300 min of individual ST. Before participants start the group treatment, they receive two individual preparation sessions in which psychoeducation is given, a case conceptualization is made which includes an overview of actual complaints, events which contributed to the creation of maladaptive schema and modes, a mode model is made and goals are defined. Every 10th or 20th time, members who completed 30 sessions say goodbye and in the following session new members enter the group. The 30 weeks GST is divided into three phases. with a fixed procession of elements. The first phase (Weeks 1–10) is aimed at facilitating mode awareness among group members. The

**TABLE 2** Overview of fixed elements of GST for CL-C

| |
|---|
| 1. Welcoming the group members. |
| 2. Attention exercises to focus on the Here-and-Now or exercises that bring the participants out of their chair: such as ball games, speed dates etc. |
| 3. Announcements and possibility to come back on previous session. |
| 4. Discussing homework; this is kept short by naming common factors. |
| 5. Addressing a new subject or theme; for example a mode, psycho-education or management techniques. |
| 6. Pause |
| 7. Experiential exercise such as chair technique, an imagination or an imagination with rescripting. |
| 8. Reflection on the session writing down notes individually. |
| 9. Homework for next week |
| 10. Happy child exercise |

Abbreviations: CL-C, cluster-C; GST, group schema therapy.

second phase (Weeks 11–20) focuses on mode management by practicing new behavioral, emotional and cognitive abilities to handle modes and practicing fulfillment of basic needs. The third phase (Weeks 21–30) is aimed at facilitating the use of these new skills in their own context. Exercises during GST and homework are therefore divided in these three phases, to facilitate the goals per phase. The different modes are dealt with in a cycle of 10 sessions and this cycle repeats itself three times (see Table 2). For each mode, mode awareness, mode regulation and experiential techniques are used. This is done in differential forms of depth, partly depending on the number of sessions the group members have followed. As a result, group members are given different forms of assignments during an exercise. Homework is also given in differential forms, depending on the phase the patient is in. In GST for CL-C PD experiential exercises play a crucial role to counter the much present avoidance. After 30 sessions, the weekly group sessions end. There are four monthly group booster sessions to maintain and further generalize what has been achieved. The clearly defined duration of the trajectory stimulates patient's responsibility for change (Tjoa & Muste, 2020).

Group members do not have an individual therapist next to the group. Patients however have 300 min of individual time, which they can use during the 30 GST sessions period for an individual session with one of the group therapists. New patients are stimulated to plan an individual session in the first 10 sessions to reduce uncertainty and tension of entering the group. In individual sessions possible fears are addressed and possibilities to connect to the group. Furthermore, individual time can be used for more individual imagery rescripting, for example, in the case of traumas. In the following, a case illustration is given of the GST protocol for CL-C PD's.

## 8 | CASE ILLUSTRATION

### 8.1 | Presenting problem and client description

Jim is a 37-year-old divorced man, father of two kids, who was referred to a specialist mental health care center for treatment of chronic depression, suicidal thoughts, and a suspicion of personality pathology after discharge from a high intensive care unit. During the assessment phase the following DSM-5 classification was made based on MINI-plus and SCID-5-P interviews (American Psychiatric Association, 2013): major depressive disorder, recurrent episodes, avoidant PD, other specified PD: borderline PD traits, migraine, obesity, binge eating disorder, problems

with work, partner relationship and primary support group. Because avoidant PD was the main diagnosis GST for CL-C PD was indicated.

CL-C-PD patients are often referred for treatment of anxiety and mood disorders, because of underdiagnosis of PD's (Hutsebaut et al., 2018). Patients with PD often receive several other not PD-focused treatments before a PDoriented treatment is offered (Bamelis et al., 2015). Jim previously received individual and day treatment CBT for depression and used various medications (SSRI, benzodiazepines). He also received EMDR for PTSD-like symptoms related to the conviction of his brother for child abuse. Jim felt guilty that he did not tell his parents that his brother had stacks of children underwear in his room. Jim was thereafter admitted to the high intensive psychiatric unit since he experienced a setback in functioning with depression, self-injury (cutting), suicidal thoughts and plans to attempt suicide and homicide of his children. This was possibly initiated by the EMDR which was terminated after two sessions due to emotional dysregulation and upheaval of early childhood memories after which Jim was taken into a high intensive psychiatric unit.

Jim grew up in a family in which he did not feel safe and connected. Jims father was very dominant, his brother showed behavioral problems of aggressive nature and his mother was emotionally instable and strongly focused on her own emotions and the behavioral problems of Jim's brother (not directly directed to Jim). Jim's brother got convicted for sexual abuse of several children, a violation that occurred more often in Jim's family. His grandfather and uncle were also convicted for sexual abuse of children. Jim grew up with the feeling that his feelings and thoughts did not matter to his family members and that he was unworthy of the concern of them. Jim's parents did not pay much attention to Jim. Jim suffered from migraine attacks and developed binge-eating problems at the age of 14 and got severely bullied about his migraines, shyness and weight of his mother at primary and secondary school by peers. He did not feel connected with his classmates, and had only one good friend. He was shy and timid in the classroom and detached from his peers. He, however, performed well at school and managed to complete his study for a teacher's certification. He met his ex-wife during college, who was according to Jim, suspected of having a form of autism. She did not want to be tested for autism. Jim and his wife frequently had relational problems during their marriage. They divorced 2 years ago. Jim and his ex-wife have two kids (6 and 9 years) one diagnosed with autism and the other with attention deficit disorder. They had a 50% coparenting arrangement. They had frequent conflicts about childrearing. Jim had anxieties that his children could be hereditary burdened with behavioral problems and propensity towards sexual abuse, like his family members. Jim worked as a teacher for a while but was not able to work since several years due to his symptoms. Jim had daily contact with his parents, he felt controlled and judged by them, especially on his parenting skills.

## 8.2 | Case formulation

In the first two individual sessions creating safety and a therapeutic alliance, by validating feelings, thoughts and encouraging expression, are a main focus besides gathering and giving information on GST (more specifically: general information on ST, group rules, schema and modes). Two individual sessions were delivered before entering the group. In the first sessions Jim reported that his main problem was his avoidant behavior (an avoidant protector mode), more specifically avoiding conflicts with others and expressing his thoughts and feelings. He was suffering from lots of negative thoughts about himself (a punitive parent mode), which paralyzed him resulting in inactivity that in turn resulted in problems in keeping up his household and self-care. Jim who was quiet open in the first contacts, looked untended, tired and in an unhealthy condition. He also mentioned having problems with dealing with sadness and anger (vulnerable and angry child modes). His way of coping with these feeling was avoidance of feelings, self-injury and vomiting (detached protector), or binge eating, and obsessively watching movies (self-soother mode). Jim's goals for GST were: becoming more assertive, less avoidant (of own feelings and expression of feelings and needs), and less punitive towards himself. He also would like to stop with binge eating and self-injury. Jim experienced his tendency to avoid sharing in the group and asking for time and attention in the

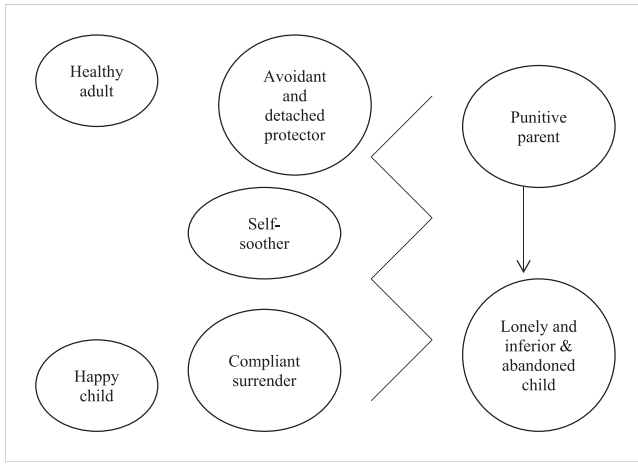


**FIGURE 1** Mode model of Jim

group as major pitfalls for GST. Jim therefore asked for help from the therapists to stimulate and help him to express his feelings during GST.

A case formulation was made during the two individual ST sessions. Schema's and schema modes were assessed with YSQ and SMI (Young et al., 2007; Young, 2005). In Jim's case a lack of fulfillment of his basic needs of secure attachment, love, nurturing and attention, expression and validation of emotions, and opinions in early childhood was assumed to lead to several dysfunctional schemas and schema modes, generating clinical symptoms such as depression, eating disorder, and self-injury. The central theme in Jim's problems was the idea and feeling that his feelings and thoughts did not matter to others (schema Emotional deprivation) and that he was unworthy of the concern of others (schema Defectiveness/shame). In line with this, Jim's primary schema was Emotional deprivation (4.8), followed by Emotional inhibition (3.8) Subjugation (3.6) Self-sacrifice (3) and Defectiveness/shame (3) (Young, 2005).

An idiosyncratic mode model (Figure 1) was made based on SMI scores (Young et al., 2007) and clinical impressions. Highest modes in SMI were avoidant protector (4.3), compliant surrender (3.77), detached protector (3.22), self-soother (3.22), abandoned and abused child (2.8) and lonely and inferior child (2.8). Jim often felt lonely, inferior and abandoned from other (abandoned and abused and lonely and inferior child mode) resulting in clinical depression and suicidal thoughts and plans. Jim was often very critical about himself, he often disapproved his feelings and he thought he was worthless (punitive parent mode). His way to avoid confrontation with these feelings and thoughts was to either surrender to others (compliant surrender mode), avoiding others (avoidant protector) and detaching from self and others (detached protector) and self-soothing behaviors such as eating and self-injury by scratching himself (self-soother mode).

## 8.3 | Course of treatment

GST for Cl-C PDs consists of 30 sessions, divided in three phases of 10 sessions.

## 8.4 | First phase

The primary aim of the first phase for all new group members is creating mode awareness. Jim was a bit cautious and hesitant during first group sessions, he gave short responses on invitations of the therapists to share personal

information, feelings and thoughts. Jim did participate actively in all the GST exercises, in first instance possibly out of his tendency to comply to the request of the therapist (compliant surrender mode). Both GST therapists felt little emotional connection with Jim, indicating that the detached protector mode was dominant. Occasionally emotional responses to GST exercises were visible (tears in his eyes). We dealt with this by validating his emotional response and promoting expression of feelings and thoughts, and stimulating attachment connections, in the light of countering emotional deprivation, which was one of the major underlying problems of the vulnerable child of Jim.

First therapist: "*I can see that this exercise made you a bit emotional, can you share your feelings and experiences with us? It seems your vulnerable child got activated" (mode awareness)*. Jim: *It makes me sad to hear about basic needs of children (psychoeducation), it makes me realize that in my family there was very little room for how I felt*. First therapist: "*That must be difficult for you to realize, how painful to realize that your needs were not met as a little child. You needed your parents to be sensitive to your feelings*." Second therapist: "*do others recognize Jim's feelings?" (promoting recognition and validating of feelings among group members and underlining similarities with other group members)*.

Notably Jim missed several GST sessions in the first phase, due to illness of himself (migraine and flu) and problems arranging a babysitter for his children. This was discussed in the group by performing a chair exercise with Jim, to investigate which modes were involved in his absence (i.e., avoidant protector, punitive parent mode and vulnerable child mode) and reparenting his vulnerable child by letting him feel that we missed him during GST and wanted to connect to him especially when he was not feeling well.

First therapist: "*Jim, let's investigate together which modes take part in your absence in the group. Can you describe what you think and feel when you decide not to attend the group?*" Jim: "*I find it difficult to ask my parents to babysit. I often feel that I'm a burden to them and I shouldn't ask so much of them (punitive parent mode). I find it stressful to ask them for help and eventually decide not to ask for help" (avoidant protector)*. Second therapist: "*group members, which modes do you recognize in Jim's difficulties in asking for help? And what do you think Jim actually feels and needs in this case?" (promoting mode awareness in Jim and the entire group)_*

Jim asked for an individual session after five GST sessions. In this session he shared that he was having difficulties with bringing up his children who showed behavioral problems. Jim and his ex-partner just had an umpteenth argument about how to handle these problems, which made hem think and feel that he was handling his kids incorrectly. Jim was thinking that he had failed as a parent which made him feel sad and anxious (punitive parent and vulnerable child). Furthermore he felt anxious in the group about what others thought of him and he was scared group members would condemn him (punitive parent and vulnerable child mode).

Therapist: "*thank you for sharing this with me Jim, I feel privileged that you feel safe enough to share this with me. It must be very intense and difficult for you raising two children on your own with behavioral problems (validating vulnerable child). I can hear that this situation triggers your punitive parent mode. I will put this part in the hallway. Punitive part, I need you to leave this room, you're only giving Jim critique, and this doesn't help Jim in being a good parent for his kids. You're only making Jim sad and depressed. This part doesn't bring you any good. So now just leave Jim alone, go away and don't come back again*. Jim: *weeps a bit*. Therapist: "*I can see you feel sad, Jim I want you to know that I think you're doing your utmost best in raising your kids, you are trying to be the best parent you can be. It must be difficult for you feeling criticized by your ex-partner. Let's investigate what happens in such situations, which modes are present at such interactions. Let make a mode circle together to investigate this difficult situation*."

In the following group session Jim spontaneously shared, that he was having difficulties with his ex-wife and the upbringing of his children, which was a shameful subject for him. He got acknowledged and validated by group members who substituted in and stood up for him towards his ex-wife. This corrective experience was of importance for Jim's presence in the group. He felt support from the group. Jim was accepted and validated by his group members and got more connected to others. Our observations were that after this experience he became more open in the group, indicating that his detached protector diminished in the group. Jim was able to open up more and show what was behind his detached behavior in the group (detached protector), his vulnerable feelings of worthlessness (child mode) and his enormous self-criticism (punitive parent mode).

## 8.5 | Second phase

Jim's aims for the second phase were: diminishing negative self-judgment (punitive parent mode), less avoidance of assertive behavior (avoidant protector mode) and overeating and self-injury (self-soother mode). In this phase Jim's was more present in the group. He shared how lonely he was feeling and how insecure and worthless he felt (vulnerable child and punitive parent mode). Jim mentioned an increase of overeating and cutting. In our experience this is quiet commonly reported by patients in GST for CL-C, as patients' coping strategies slowly diminish and vulnerable feelings (child mode) and self-criticism (punitive parent modes) become more prominent and patients lack new (healthy) strategies to deal with these painful feelings and critical thoughts. Notably this pattern is not shown in the results of the assessments of Jim, in which a general reduction of dysfunctional modes and psychopathology is dominant—apparently there is a discordance between subjective experiences (participants becoming more aware of their problems) and the actual manifestation of the problems. Jim shared with the group that he was experiencing difficulty with dealing with his emotions. The group setting gives many opportunities to experiment with expressing emotions and new behaviors with different people. Since several group member recognized this aspect, special attention was given to first aid for modes in session twelve.

Therapist: "*of course you are having difficulties dealing with stopping the self-criticism (punitive parent mode) and healing and soothing your vulnerable child modes feelings. The old survival mechanism (coping modes) you learned in your family of origin brought you lots of benefits, they helped you dealing with your shortcoming environment. These coping modes however in the long run did not help you to change your vulnerable feelings. Let's investigate together which new strategies you can practice to help your vulnerable child to deal and heal these feelings. Who has an idea what you can do when you're feeling lonely? Let's all brainstorm on possible solutions on this issue.*" This stimulates vicarious learning from one another. Second Therapist: "*write down all suggestions and categorize these suggestions in behavioral, experiential and cognitive strategies.*" First therapist: "let's try one of these *strategies. Close your eyes and imagine that your vulnerable child is sitting on your lap and is feeling sad and lonely. Let's all try to sooth your vulnerable child by comforting and reassuring him/her by our words and consoling.*"

Jim shared that he profited a lot of holding the yarn of wool form the web exercise when he was feeling lonely, which reminded him of his connection to the other group members. Jim learned to develop trust in other people by bonding with other group members. At home Jim practiced a lot with the imagination exercise of soothing his vulnerable child, which helped him feeling less lonely and worthless. Jim mentioned about the power of imagination: "Imagination became a kind of 'friend' of mine. Whenever I had a hard time, felt insecure, uncomfortable, or need to do something that I feel very anxious about, I sit down and use an imagination technique. After that I feel much more at ease."

Part of the GST CL-C PD is that every group is at least subject to one, preferably two individual imagery rescripting in the group. Individual imagery rescripting in the group is done in the second and third phase at session 16–27 and 26–27. Group rescripting is very powerful because of the strengthened limited reparenting effect, because besides 'two parents', there are also several 'brothers and sisters' in the group. Group members are asked to prepare a situation that they want to rescript in the group preferably a situation, which contributed to the schemas of the vulnerable child. In session 16 Jim choose to rescript a situation in which he was neglected by his parents. Therapist: "*Jim please close your eyes and find an image of when the neglect happened. Start at the beginning of the situation and tell me what happens in the present tense from the viewpoint of you as a child. Tell me what you see, hear, feel, and smell?*" Jim: "*I'm sitting at my room alone after school. I feel lonely my parents aren't speaking to me for several days. Therapist: tell me what happens? Jim: I hear my father arguing with my brother down stairs.*" Therapist: "*What do you feel?*" Jim:"*I feel down and depressed, so lonely.*" Therapist: "*where in your body do you feel this?*" Jim:"*in my stomach.*" Therapist: "*what do you think?*" Jim:"*I think I'm a burden to them; I'm worthless.*" Therapist: "*what do you need? Jim I need somebody who cares for me.*" Second therapist: "*group what do you think Jim needs in this situation?*" Client 1: "*someone who stands up to his parents.*" Client 2: "*love and attention from caring parents.*" Client 3:"*a safe and warm home.*" Client 4: "*a few good friends.*" Therapist: "*Jim, you heard several good suggestions from your group*

*members, which one appeals to you?*" Jim: "*I would like that somebody stands up to my parents.*" Therapist: "*I am now with you. Can you see me?*" Jim: "*Yes.*" Therapist: "*Jim I'm here with you now I'm going to take care of you. It's not your fault that your parents are ignoring you. You're just a child and your parents need to take care of you. I'm going to speak to them. Do you want to come with me, or do you want to stay here?*" Jim: "*I want to come with you.*" Therapist: "*continues, confront parents and takes care of Jim by providing a nanny who takes care of Jim and educates his parents on good parenting. Jim felt less lonely and worthless and felt strongly connected to his group members who stood up for him. Second therapist stimulates expression of feelings and thoughts of group members about the rescripting.*" Jim became more open in the second phase and experienced that by practicing new healthy strategies to deal with his feelings he was becoming more capable to deal with painful feelings.

## 8.6 | Third phase

Jim's aims for the third phase were: stopping his self-criticism (punitive parent mode), assertive behavior to his children, parents and ex-wife, and expressing his feelings and needs to others (healthy adult mode). Jim exercised in the group with a role-play situation in which he stood up to his mother, who criticized him regarding his parenting skills. During this role-play it became visible that his punitive parent mode had a large share in the difficulties he was experiencing in speaking up to others. We invited him for an individual session in which an individual rescripting was performed on a situation in which mother criticized little Jim. Jim's healthy adult part was asked to speak up to his mother, with the therapist coaching him. He was asked to daily exercise with imagining himself standing up against his punitive part by muting his punitive part with duct tape. Connected to this theme, the group also made an effigy together of their punitive parent, which was evicted from the therapy room, after which the group created one good parent with paper and pencils. All group members joined in and received a photo of this good parent. Part of the homework in GST is to practice giving good parent messages to oneself at home. Group members are also asked to give compliments to each other on a note which is passed around so that each group member receives 10 good parent messages.

A powerful exercise in GST is a chair exercise in which all group members participate. Jim was asked to sit in the vulnerable child chair. In front of him his coping modes were seated. His punitive parent and good parent were then placed before the coping modes. Next Jim was asked to express the thoughts and behaviors of each mode. Group members were then each seated in a mode chair and asked to all together simultaneously articulate the thoughts, behaviors and feelings of the specific mode they were seated in. Therapist: "*Jim how do you feel at this moment, which impact does your punitive part have on you. What would you like to do with the setup and presence of all these modes?*" Jim: "*I feel so worthless now; I can only hear my punitive part telling me that I'm worthless. I want it to stop.*" Therapist: "*How can we make it stop?*" Jim: "*Let him go away.*" Therapist: "*good idea Jim lets place this part in the hallway (externalizing the punitive part and stopping the impact of this part on Jim by muting it). Now lets try again. Therapist asks all group members to articulate the thoughts and feelings of the mode they are representing again.* Finally after relocating all coping modes and lowering their volume, the second *therapist stands next to Jim and looks directly at him*: "*Jim I want you to know that you are good enough as you are; you are worthwhile, your feelings matter to us. We like you very much.*" Jim: *cries in the group, telling the group that he was totally overwhelmed by these messages. He was accepting the messages of the therapist and group members.* Jim made good progress in the group and acquired a senior position in the group, thereby giving hope to others. He felt able to speak up to his kids, ex-wife and parents. Jim also applied for a gastric bypass after completion of the GST which resulted in a wait loss of 50 kg and a complete physical metamorphosis. Jim also started working again at a primary school. Group therapy helped Jim to develop trust and connection in other people by bonding with the other group members and experimenting with expressing emotions and new behaviors in the group. Dysfunctional beliefs were changed, by reparenting from the group members on numerous occasions but especially in the chair exercises and imagery rescripting. Jim was feeling valuable and connected to others.

## 8.7 | Booster sessions

During the booster sessions no new techniques are practiced, group members share their progress and investigate together how to deal with certain situations and specific modes. Jim steadily further improved. In accordance with his psychiatrist, he further reduced the use of several psychiatric medications, where thereafter all medication was remediated.

## 8.8 | Outcome and prognosis

Several measures were performed to measure personality severity, schemas and modes, complaints, quality of life and happiness. Table 3 gives an overview of baseline and follow-up results on these domains. A significant reduction of personality severity, schema and modes was achieved, i.e. personality functioning. Jim also reported a significant reduction in complaints such as depression and anxiety and improvement of quality of life, happiness and self-esteem. Jim described his achievements as follows: "Due to the group schema therapy I became a completely different person. I do not longer allow anybody to walk over me. I'm able to notice my boundaries and express my opinion. I'm much more self-confident. I've learned that I have a right to exist and that my opinion is of value as much as anyone else's. I have a positive perspective on life, energetic and full of life."

Very notably is the significant improvement in level of functioning during the year after completion of the GST program. These kinds of improvements are quiet common in research and clinical practice (Bamelis et al., 2014) and can give hope to therapist, group members and individual clients, since they often find it difficult to terminate therapy. We hypothesize that stimulating patients to solve the problem independently, without the help of their therapists, helps them build confidence in their own possibilities in dealing with life. Based on the results we believe that Jim's prognosis is very good.

## 8.9 | Clinical practices and summary

Jim's case is a prototypical case of a GST trajectory for avoidant PD. Jim received several other outpatient and inpatient therapies yet was still suffering from serious depressions and a poor quality of life which lead to high societal costs. Unfortunately, Jim's case is not unique. Waiting lists for PD-treatments are long and many clients with PDs do not receive adequate treatment (Bamelis et al., 2014). This situation creates a major risk for escalation of clinical disorders, unnecessary chronicity, and long treatments. Early detection and treatment of CL-C PD's is needed. Based on Jim's results and the preliminary data of the GST pilot trial, GST seems a very good option for treating CL-C PD's and dealing with the persistent avoidant and controlling coping strategies of patients with CL-C PDs. Preliminary data of a recent pilot study suggests that GST is highly acceptable and effective for CL-C PDs and double diagnosis group of patients with avoidant PD and Social Anxiety Disorder (Arntz et al., 2021; Baljé et al., 2016). Compared to IST, the GST protocol implies a 50% reduction of therapist time, implying that in theory twice as many patients can be treated for the same costs. However, presently there is no RCT supporting its (cost-) effectiveness. Costs other than related to direct application are unknown. Documenting the (cost-) effectiveness of GST is therefore an urgent issue. It is important that this protocol is tested in an adequately powered RCT to investigate cost effectiveness of GST versus individual IST and TAU. Moreover, it is unlikely that GST is applicable to everyone—some patients might respond better to IST, for instance clients with specific diversity characteristics, introverted, sleep disordered or highly traumatized clients. Matching treatment to client (personalized care) also reduces societal costs and demoralization in clients who are not helped by their treatment. Consequently, we need a better understanding of which treatment to select for whom.

**TABLE 3** Results on outcome measures at baseline, after completion of GST and follow-up

| Measure | Baseline | After 30 weeks | 1-year follow-up |
|---|---|---|---|
| Avoidant Personality Disorder Severity Index (AVPDSI; Balje, et al.; in prep) | 32.5 | 20.21 | 17.93 |
| Personality Disorder Beliefs Questionnaire (PDBQ); Arntz et al., 2004 | | | |
| Dependent | 34.58 | 9.54 | 1.0 |
| Avoidant | 37.97 | 6.7 | 1.0 |
| Obsessive compulsive | 25.48 | 10.93 | 1.0 |
| Schema mode inventory (SMI; Bamelis et al., 2011) | | | |
| Lonely child | 2.82 | 1.73 | 1 |
| Abused and abandoned child | 2.83 | 1.92 | 1 |
| Angry child | 2.91 | 1.73 | 1.3 |
| Raging child | 1.14 | 1.14 | 1 |
| Impulsive child | 1.38 | 1.5 | 1.1 |
| Undisciplined child | 1.71 | 1.43 | 1.1 |
| Dependent child | 2.4 | 1.7 | 1.1 |
| Compliant surrender | 3.77 | 1.67 | 1.1 |
| Detached protector | 2.77 | 1.92 | 1 |
| Detached self soother | 3.22 | 1.89 | 1 |
| Avoidant protector | 4.3 | 1.7 | 1 |
| Self-aggrandizer | 1.3 | 1.1 | 1 |
| Perfectionistic overcontroling | 3.2 | 1.8 | 1.3 |
| Suspicious overcontroling | 2.44 | 2.11 | 1.1 |
| Attention and approval seeker | 1.5 | 1.67 | 1 |
| Punitive parent | 2.36 | 1.64 | 1 |
| Demanding parent | 2.7 | 1.8 | 1.2 |
| Healthy adult | 2.55 | 4.36 | 5.4 |
| Young schema questionnaire (YSQ; Young, 2005) | 4.2 | 4.6 | 1.4 |
| Emotional deprivation | 2.8 | 1.8 | 1 |
| Abandonment/instability | 2.6 | 2.6 | 1 |
| Mistrust/abuse | 2.4 | 1.4 | 1 |
| Social isolation/alienation | 3 | 2 | 1 |
| Defectiveness/shame | 1 | 1 | 1 |
| Failure to achieve | 2.4 | 1.6 | 1 |
| Dependence/incompetence | 2.4 | 1.4 | 1 |
| Approval-seeking/recognition-seeking Negativity/pessimism | 2.8 | 1.6 | 1 |
| | 2 | 1.6 | 1 |

**TABLE 3** (Continued)

| Measure | Baseline | After 30 weeks | 1-year follow-up |
|---|---|---|---|
| Vulnerability to harm or illness | 2.8 | 2 | 1 |
| Enmeshment/undeveloped self | 3.6 | 2.2 | 1 |
| Subjugation | 3 | 1.8 | 1.4 |
| Self-sacrifice | 3.8 | 1.6 | 1 |
| Emotional inhibition | 2 | 1.6 | 1 |
| Unrelenting standards/hypercriticalness | 1.8 | 1.2 | 1 |
| Entitlement/grandiosity | 3 | 1.4 | 1 |
| Insufficient self-control/self-discipline | 1.6 | 1.4 | 1 |
| Punitiveness | | | |
| Self-esteem (Rosenberg, 1965) | 16 | 25 | 27 |
| EuroQol EQ-5D-5L Quality of life (Herdman et al., 2011) | 75 | 61 | 81 |
| Brief Symptom Inventory (BSI; Derogatis & Melisaratos, 1983) | 1.30 | 0.34 | 0 |
| Happiness | Fairly happy | Fairly happy | Very happy |

Abbreviation: GST, group schema therapy.

## PEER REVIEW

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## DATA AVAILABILITY STATEMENT

Data available on request from the authors.

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