‘The Good, the Bad and Defenceless Jimmy’—A Single Case Study of Schema Mode Therapy

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This paper presents a single case study, which outlines the innovative application of a new approach to working with a complex clinical case, for whom all other forms of therapy, including drug therapy, psychoanalytic therapy, hypnotism and traditional CBT interventions, had been found to be ineffective. It describes the use of Jeffrey Young’s Schema Mode Therapy in the treatment of a 47 year old man with a 30 year history of chronic agoraphobia. The results obtained in terms of the clinical outcome of this single case study are very encouraging and indicate that Schema Mode Therapy may indeed be an effective form of therapy for certain types of complex case, for which more traditional approaches have been unsuccessful. Copyright © 2004 John Wiley & Sons, Ltd.

INTRODUCTION

The traditional Beckian model of cognitive therapy (Beck, 1967, 1976) has been applied to a wide range of psychological problems including depression (Beck et al., 1979), anxiety (Barlow, 1988) and eating disorders (Fairburn et al., 1991), to name but a few examples. It has also been applied to personality disorders (Beck et al., 1990). However, Young (1994) found that some patients were particularly resistant to and did not respond well to the traditional cognitive therapy approach, due to their early maladaptive schemas (EMSs) sabotaging the therapy and making it difficult for such patients to meet many of the assumptions of the traditional cognitive—behavioural therapy (CBT) approach.

Early maladaptive schemas (EMSs) are broad pervasive themes or patterns regarding oneself and one’s relationships that are dysfunctional to a significant degree, which are developed during childhood or adolescence and are elaborated throughout one’s lifetime. These schemas are triggered when the individual encounters environments reminiscent of the childhood environment that produced them, and when this happens there is an intense and often overwhelming negative affect elicited. There is a growing body of evidence for the existence of early maladaptive schemas (Schmidt, Joiner, & Telch, 1995; Rittenmeyer, 1997; Carine, 1997; Lee, Taylor, & Dunn, 1999). It was originally believed that the main difference between EMS and Beck’s underlying assumptions (Beck et al., 1979) was that EMSs are unconditional, whereas underlying assumptions are conditional. It was thought that having EMSs hold out little hope for the individual, since they were seen as

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unchangeable and unquestionable truths about the person, whereas underlying assumptions were thought to hold out some hope for the individual, since they could be changed. However more recently, it has been argued that many schemas are conditional and can be modified to enable the individual to escape from their dis-abling ‘life-traps’ (Young & Klosko, 1994; Young et al., 2003). Generally, however, it is still recognized that schemas that are developed earliest and are most at the core are more difficult to change than those that are developed later on in childhood.

Schema Focused Therapy (SFT) was developed by Young (1994) specifically to work with patients who did not respond too well to the traditional cognitive approach. In particular, it was developed for patients with ‘characterological’ problems, those with a diffuse presentation and often ill defined complaints that did not fit into current illness classifications (e.g. DSM IV, 1994), who were not able to identify specific triggers and yet displayed very significant disturbance in personal adjustment over time. Schema Focused Therapy is a broad integrative therapy, which combines interpersonal and experimental techniques within a cognitive behavioural (CBT) framework but with a greater use of the therapeutic relationships and affective experience as vehicles for change than the traditional CBT model.

Young (2000, 2001a) and Young et al. (2003) reported that even the schema focused approach (SFT) itself was not effective in treating some of the more complex cases encountered in therapy. These included individuals with extremely rigid avoidant or compensatory coping styles, those who were highly self-critical or self-punitive and those with internal conflicts, which made them feel confused and which resulted in sometimes frequent and rapid changes in mood and/or coping style. He identified that with some complex cases individuals may have as many as 14 or 15 early maladaptive schemata at once, which made it impractical to use the schema focused approach. He therefore developed the concept of ‘schema modes’. Schema modes blend a number of schemas into one and so there are fewer of them, allowing therapy with such patients to become manageable.

A mode is defined by Young et al. (2003) as ‘an enduring “facet” or part of the self that has not been fully integrated with other “facets” or parts of the self’. In normal healthy individuals, it is thought that modes are well integrated and that the individual moves smoothly between modes and has awareness of their other modes (work mode, party mode etc). The mildest manifestations are akin to ‘moods’, which we all experience, and in normal healthy individuals one mood clicks in smoothly as another clicks out. The experience is one of a unified self with seamless transitions. However, as one moves along a continuum of dissociation and identity disturbance, the greater the level of dissociation and disintegration of normally integrated processing systems becomes (Ryle, 1997; Golynkina & Ryle, 1997; Pollock, 2001) and the less integrated the modes become (Young et al., 2003). Associated with this are increasing levels of amnesia, ranging from partial amnesia to ultimately complete amnesia between modes.

From Figure 1 it can be seen that at the most severe end Dissociative Identity Disorder (DID) occurs, where there are multiple separate personalities with often complete amnesia for other personalities. Borderline Personality Disorder (BPD) is also at the more severe end but less shows less dissociation and only partial amnesia between modes. In BPD, one mode is dominant and shuts the other modes off, and transition between modes is often experienced as a rather sudden and abrupt shift or ‘flipping’ from one mode to another.

Young et al. (2003) identified that most schema modes can be placed under four main headings:

1. child modes (e.g. angry child, vulnerable child)
2. maladaptive parent modes (punitive parent, demanding parent)
3. maladaptive coping modes (compliant surrender, detached protector, overcompensation modes)

![Figure 1. Continuum of dissociation and identity disturbance (adapted from Pollock 2001, page 55)](image-url)
4. healthy adult modes (nurturing, validating, affirmative).

Central to Schema Mode Therapy (SMT) is the concept of ‘limited re-parenting’. This describes the process whereby the therapist Assist the patient to develop the Healthy Adult (HA) mode. Initially the therapist develops the nurturing validating, supportive and affirming Healthy Adult mode and encourages the patient to use this mode to promote a healthier child mode, replace the maladaptive coping modes and neutralize and moderate the maladaptive parent modes. Essentially, the HA mode becomes the ‘overseeing’ mode, which assists the patient in replacing, or modifying the unhealthy maladaptive core interpersonal schemas with healthier ones and ultimately bringing about ‘healing’.

Imagery is one of the primary experiential techniques used in SMT. According to Young et al. (2003), the techniques used appear to produce profound change at an emotional level and assist the patient in the transition from knowing intellectually that their schemas are false to believing it emotionally. It is thought to turn ‘cold’ cognitions into ‘hot’ ones and assist patients to more readily identify their core unmet emotional needs as a child through enabling them to feel their schemas and to understand how they began in childhood. Since most patients can do imagery and the techniques used allow positive healthy images to be introduced to counteract the negative ones and through developing a dialogue between the modes, the process of re-parenting can take place. Thus the patient can expect to deepen their understanding of their problems, with a view to working on them in SMT.

The schema concept is not new. It can be found in Piaget’s work with children (Piaget, 1962) and Beck discussed the importance of ‘depressogenic schema’ in his cognitive model of depression (Beck, 1967, 1976). Beck later went on to develop a taxonomy and topography of ‘core schemas’ relating to specific personality disorders (Beck et al., 1990). More recently, SFT has been extended beyond personality disorders to a wide variety of clinical problems and disorders, and a number of validation studies using the Young Schema Questionnaire (Young & Brown, 2001) have been carried out (Schmidt et al., 1995; Lee et al., 1999; Shah & Waller, 2000; Waller, Meyer, & Ohanian, 2001; Stopa et al., 2001).

Similarly, SMT is more recently being used to treat a wider range of DSM IV disorders with higher functioning patients, including anxiety disorders, substance abuse, eating disorders, chronic pain and post-traumatic stress disorder (McGinn, Young, & Sanderson, 1995) and in the prevention of relapse in depression (Young, Beck, & Weinberger, 1993). To date the results are extremely promising (Young & Behary, 1998).

The current thinking (Young et al., 2003) is that SFT and SMT are not two separate therapies, but mode work is seen as an advanced component of schema work, which can be used whenever the therapist feels blocked. It is of course recognized that as the evolution of theories and models associated with any new clinical treatment the evidence base takes time to accumulate. It begins with single case studies, followed by case series and eventually randomized controlled trials are conducted before the level of evidence base is reached for example of that for CBT for depression. However, the evidence for the efficacy of SFT and SMT, although in its infancy, is accumulating, and hopefully the present single case study makes a contribution towards this goal.

THE CASE OF DEFENCELESS JIMMY

This case study was chosen to illustrate Young’s Schema Mode Therapy in action. The information was collated through reviewing Jimmy’s past medical, psychiatric and clinical psychology case notes, as well as through his history taken during the clinical assessment interview. It represents an innovative application of the model to the treatment of a 47 year old man known as ‘Jimmy’, with a 30 year history of ‘chronic agoraphobia’ (as defined by the DSM IV criteria). Through case note review and interview it was established that all other forms of therapy tried by Jimmy (including drug therapy, psychoanalytic therapy, hypnosis and traditional CBT interventions) had been found to be ineffective. Whilst some information about previous therapies was available, it was not possible to ascertain whether the therapies were conducted in a ‘pure’ form, but the case note review provided sufficient evidence that the therapies were conducted by suitably trained professionals. In addition, the fact that the first 12 sessions of therapy conducted with Jimmy in the present case study adopted a more pure traditional (Beckian) CBT approach within a specialist CBT service, without success, added weight to the view that traditional approaches to Jimmy’s problems were ineffective.

In light of the fact that traditional approaches were found to be ineffective, therapy in the present...
case study progressed to the standard SFT approach developed by Young. However, even with using a SFT approach, the therapist still felt ‘blocked’ by the patient’s resistance and rigidly avoidant coping style (one of Young’s criteria for the use of SMT). The patient had felt unable, or was unwilling, to engage in the necessary collaboration required by the more traditional approaches employed and did not do any of the homework tasks set. Also, given the complexity, chronicity and severity of Jimmy’s presentation it was decided that an alternative approach (SMT) should be introduced. From the very outset, Jimmy reported that he liked the description of the mode model and stated that it made ‘more sense’ to him than any other psychotherapeutic model he had encountered.

At the time of referral Jimmy was unable to leave the house unaccompanied and went everywhere with his elderly mother. Any attempts to do things outside the home without his mother usually led to panic attacks. He was socially very isolated and lonely, unable to drive his car or go into shops or cafes or any crowded places. He had been unemployed (and indeed unemployable due to his agoraphobic condition for many years) since 1985, and had not been in a relationship with a woman for 25 years. On a positive note, Jimmy was psychologically minded and at the time of referral was doing an Open University degree correspondence course in psychology. However, he was (not surprisingly) very sceptical about the likelihood of any psychological treatment being effective with his own problems, given the history of unsuccessful therapies he had undergone. Overall, Jimmy was displaying chronic avoidance of many situations and a strong dependence upon his mother accompanying him to go anywhere.

**Personal History**

Jimmy was born in Derbyshire in 1955, the younger of two brothers (by four years). He described himself as ‘materially’ spoilt and wanting for nothing materially, but from an emotional perspective felt very deprived from an early age. He recalled that his relationship with his father in particular was very poor. His father spent very little time with either him or his brother, believed ‘children should be seen and not heard’ and openly admitted that he never really wanted or liked children. He described his father as very punitive and bullying and recalls being hit a lot by his father, but not knowing the reasons why. Whilst his father presented a respectable face to the world, Jimmy described him as a ‘weak, asocial, worrying, malicious man’ who took his frustrations out on him and his brother, usually when his mother was out of the house. Jimmy recalled that he began to avoid certain situations, which he perceived would have negative consequences for him in terms of his father’s ‘wrath’, from an early age. He described himself as being close to his mother, although she would collude with him in avoiding things that he did not want to do both at school and at home. She would write letters to enable him to stay off school and avoid games and always used to emphasize the dangers in the world and the importance of not taking risks.

Jimmy reported that he did not enjoy school. He described himself as the ‘fat kid’ at school and that he got badly teased and bullied. He also recalled incidents at school where teachers would join in with the teasing and on one occasion initiated the teasing, leading a chorus of ‘lazybones’ when he was late for school one day. He also recalled not being allowed to go to the toilet by a teacher when he was desperate to go. Eventually, he became reluctant to attend that teacher’s class in case he needed the toilet and was not allowed to go. He recalled beginning to avoid a number of situations where he had no escape route such as school trips and physical education and began sitting at the end of the row in his class. His ‘learned avoidance’ and ‘taking the line of least resistance’ was assisted and reinforced by his mother, who supported him in his avoidance and wrote letters on his behalf to the school excusing him from activities which he found difficult and anxiety provoking. Over time, Jimmy began to avoid a wide range of situations where he had no escape route such as travelling on buses and in cars and even going to the cinema.

Jimmy described an incident that he felt had a life changing impact on him when he was 16 years old. He had an ‘arm wrestling’ competition with his dad and beat him. After this he said he became more confident and sociable and began to stand up for himself more. He began confronting things rather than avoiding them and he felt that life changed considerably for the better. He left school, got a job on a farm, got a girlfriend, purchased a motorcycle and began to wear more trendy clothes. In fact he described himself as a ‘normal teenager’, who enjoyed drinking and parties with friends and really believed he had left his past behind him. Unfortunately, this was not to be! Two incidents occurred in 1971 when Jimmy was still 16 years
old, which for him re-activated all the old thoughts, feelings and behaviours, which came flooding back with a vengeance and shattered his fragile self-confidence. On the face of it they could be seen as relatively minor, but for him marked the start of a long and unhappy association with mental health services. The first incident occurred at a party, which was hot and stuffy. People were smoking dope and, whilst Jimmy himself had not smoked any, he began to feel panicky and needed to escape. The second incident occurred a few months later when he was at a school disco with his girlfriend, who was paying more attention to her friends than to him. He believed she was no longer interested in him and began to feel panicky and felt he had to escape from the situation.

In terms of relationships, Jimmy reported having a few girlfriends in his teens but ‘nothing serious’. When he was 18 years old he met ‘G’, who he found reliable and dependable, but her mother disliked him and eventually ‘G’ finished the relationship. When he was 21 years old he met ‘D’, who initially was very supportive of his anxiety related problems. He described the relationship as one of him being ‘dependent’ on ‘D’. They eventually got married, but he described the marriage as a ‘sham’. Eventually ‘D’ decided she did not want to ‘be his nurse, any longer’. The marriage lasted less than two years and left Jimmy devastated. At the time of the commencement of the present course of therapy, he had not had any relationship with a female since his wife had left. He moved back home to live with his mother and had stayed there ever since. Overall, Jimmy described himself as a ‘failure in relationships’.

On leaving school in 1971 at 16 years of age Jimmy took a job as a trainee radiographer, but did not enjoy it. He described having a series of short-term (what he called) ‘crummy jobs’. He then did an Art Foundation course and began doing some photography, all at home. In 1979 he was offered the opportunity to do a training course, but declined it because it meant him having to live away from home. In 1980, he set up his own arts and crafts business using some money he had inherited, but it went bankrupt within a year. In 1981 he got a job as an ‘imagery technician’, but was sacked for poor time keeping. He reported that this was because of his increasing anxiety about travelling on public transport. Following this he did some photography work. One client referred to him as the ‘blushing photographer’ and shortly after this incident he accidentally shredded a film and lost all the photographs. Following these incidents he became too anxious to do the work and avoided it altogether. In 1985 Jimmy did some freelance photography and ‘write-ups’, for a kit car magazine and got his work published. However, the job did not develop because it required him to travel, which he refused to do. Consequently, he got little work. Overall, Jimmy described himself as a ‘failure in his career’.

History of Involvement with Mental Health Services and Previous Therapies Offered

In 1971, when he was 16 years old, Jimmy had been invited to a party where people had been smoking cannabis. The room was stuffy and smoke filled and Jimmy began to feel dizzy and hot. He began to feel ill and thought he was going to faint. He escaped into fresh air. He thought that this might have been his first ‘panic attack’. A similar thing happened the same year at a school disco, when he became panicky and he had to escape to get some fresh air. In 1974, Jimmy was due to leave home to go to college. He recalled the day as being hot and he had not had much to eat. He began feeling ‘dizzy’ and faint. He saw a psychiatrist and was prescribed Ativan. He began to fear that these dizzy spells might happen again. Jimmy experienced panic attacks regularly from 1974 onwards.

In 1984, he began to develop phobic avoidance of travel to and from work and was again prescribed Ativan, but this time by his GP.

Up until 1984, Jimmy had used drug therapy as the only way of coping with his problems but began increasingly to realize that medication was not helping him overcome his phobic anxiety, so in 1985 saw a clinical psychologist for a course of therapy that lasted for two and a half years. During this time he underwent relaxation training and a course of hypnotherapy. However, this was not successful in alleviating his symptoms. In 1988 Jimmy saw a consultant psychiatrist for a course of psychoanalytic therapy over a one year period but did not feel that he had benefited from this. He was therefore in 1989 referred on to group psychoanalytic therapy and was given a community psychiatric nurse as support. Again however, Jimmy reported little benefit from attending this group.

In 1990 Jimmy was offered a course of behavioural therapy and found that this approach was beneficial to him and he did make some improvements in managing his anxiety and confronting his fears. However, with hindsight he attributed much of his improvement to ‘positive transference’ issues.
between him and the therapist (who was an occupational therapist (OT)) and the fact that he felt attracted to her and wanted to do well and please her. He recalls them both sitting, chatting and smoking in sessions and one occasion when he repaired her car for her! Following the ending of therapy with the OT he had another panic attack whilst driving and began avoiding driving again.

From 1992 onwards Jimmy’s phobic condition became increasingly more severe and chronic. He began avoiding more things such as going into shops, travelling anywhere or even going outside on his own, and from 1991 he never went out again unaccompanied and his mother began to go everywhere with him. Between 1993 and 1996 Jimmy tried further medications including Manerix and Prozac but reported no improvement in his condition. In June 1997 Jimmy commenced a further 17 sessions of therapy with a clinical psychologist, which he found to be of no benefit. He could not say what kind of therapy this was. In 1999 he was offered yet another course of a further 17 sessions of therapy with a clinical psychologist, which he reported was along traditional cognitive behavioural therapy lines with no improvement in his condition. In 2001 Jimmy commenced the present therapy.

From the formulation in Figure 2, it can be seen that Jimmy had (as a result of his earlier experiences) developed the core belief that he was ‘useless’, others were ‘cruel’ and the world was a ‘hostile and dangerous place’. As a consequence of holding these core beliefs, he developed the rules for living that ‘difficult situations should be avoided’ and ‘If I attempt to tackle difficult situations, then I will fail’. Critical incidents appear to be around the theme of ‘fear of failure’ in a range of developmental tasks such as achieving independence, developing adult relationships and career advancement.

Jimmy had learned a rigidly avoidant coping style for any ‘difficult situation’ where there was a possible risk of failure (i.e. difficult emotionally, cognitively or behaviourally). He expressed his distress mainly in the physical symptoms and learned to ‘medicalize’ his problems. The use of the ‘sick role’ by Jimmy allowed him to legitimize his passivity and avoidance and provided a ‘solution’ to his plight. It also prevented any further erosion of his self-esteem. Unfortunately, however, his avoidance, dependence and adoption of the sick role only served to maintain his belief that he was a ‘useless failure’.

As already mentioned, Jimmy did not respond to a traditional CBT or SFT approach and the therapist felt that an ‘impasse’ had been reached. The decision to use SMT with Jimmy was made for a number of reasons. First, Jimmy met some of the criteria outlined by Young et al. (2003) for the use of SMT. These included his chronic and rigid avoidance (suggesting a vulnerable child mode), his high level of internal conflict, his failure to benefit from all other forms of therapy tried, his description of his state of ‘emotional anaesthesia’ (which for the therapist suggested the presence of a ‘detached protector’) and his tendency to be highly self-critical on occasions (suggesting the presence of a vulnerable child mode).

**Measures Used**

Jimmy had initially refused to complete any questionnaires, including the Beck anxiety and depression scales (Beck, 1990, 1996) and the dysfunctional attitudes scale (Weissman, 1978), which were routinely used in the CBT service as part of the ongoing clinical outcome audit. He stated that they were ‘a waste of time’. However, once the rationale behind the schema mode model was explained to him, Jimmy agreed to complete the long version of Young’s Schema Questionnaire (YSQ L2—Young & Brown, 1990, 2001). This was done at the commencement (Session 1) of the course of SMT and it was re-administered at Session 33. The ‘pre’ and ‘post’ measures are presented in the form of a profile in Figure 3 later on in this paper. The scoring method recommended by Young and Brown (2001) was used, with a cut-off point of 3 for each subscale. According to Young (2001b), Jimmy’s profile (i.e. the number and severity of EMSs) on the ‘pre’ questionnaire made him a suitable candidate for SMT. Young also stated that, even though the patient did not fit the DSM IV classification for a borderline personality, the approach used in SMT should be similar to that for a borderline patient. His reasoning for this was that the number and severity of EMSs made this the best way in which to work with all Jimmy’s schemas at the same time.

**THE SIX PHASES IN THE COURSE OF SCHEMA MODE THERAPY**

**Phase One (Sessions 1–5)**

‘Socializing to the Model Re-Formulation of Jimmy’s Problems Within a Schema Mode Framework’

The concept of a ‘mode’ as being a facet of one’s own personality that is currently active for an
individual in a given situation was described. Common examples of ‘modes’ we all have were used to illustrate the concept, such as when we are in ‘party mode’ or ‘work mode’, and also how such modes have associated with them a particular set of cognitions, emotions and motivations. The idea that movement between the modes in healthy individuals is smooth and seamless was introduced,
whereas individuals who have experienced trauma or adversity of some kind in their earlier life can experience these facets of themselves as not being fully integrated with each other. It was explained that in such individuals a ‘unified’ sense of self with smooth seamless transitions between modes whereby one mode clicks in smoothly as another clicks out in the form of subtle ‘mood changes’ is not experienced. Instead, the modes are less ‘integrated’ with each other and transitions between modes can be experienced as sudden abrupt shifts in mood state.

‘Re-Formulation of Jimmy’s Problems Within a Schema Mode Framework’

Jimmy was helped by the therapist to identify his child, parent, adult and maladaptive coping modes. Together the patient and therapist identified four main modes, namely the ‘vulnerable child’, the ‘healthy adult’, the ‘punitive parent’ and the ‘detached protector’ modes. The function and origins of these modes was explored and an attempt to form links between Jimmy’s current problems (and symptoms) and the modes was made, which provided a ‘rationale’ for his present predicament. He was encouraged to explore the characteristic ways of thinking, feeling and behaving motivations of each mode as facets of himself and to begin to get to know the ‘personality’ of each mode. Each mode was given a ‘name’ chosen by Jimmy, with the therapist ensuring that unhealthy modes were not given labels with positive connections. Jimmy chose the following labels, which he felt best encapsulated the images he had generated for the different modes in ‘his mind’s eye’.

(i) **The Detached Protector—’the Black Knight’**. ‘The black knight’ was described by Jimmy as a mercenary who had a job to do, and that was to stop any hurt and pain getting through. He was non-feeling, non-thinking, ‘emotionally anaesthetized’. At the commencement of therapy the black knight was very much in control and was not going to give up his power without a fight.

(ii) **The Vulnerable Child—’Defenceless Jimmy’**. ‘Defenceless Jimmy’ was a new born baby still attached by the umbilical cord. Defenceless Jimmy was described as being extremely vulnerable, timid, fearful and avoidant. He got easily overwhelmed and could not cope with very much at all and was unable to take any risks.

(iii) **The Punitive Parent—’The Multi-Headed Hydra’**. ‘The Multi-Headed Hydra’ was described as very critical and controlling and as an aggressive bully who believed that children should be kept in their place and be ‘seen and not heard’. It was described as critical, controlling, withholding and frightening to Defenceless Jimmy.

(iv) **The Healthy Adults—’Charles Darwin and Sean Connery’**. Jimmy originally chose ‘Charles Darwin’ as his healthy adult mode. Subsequently, however, he found Charles Darwin, although wise and knowledgeable, was not caring, nurturing and compassionate enough, and Jimmy replaced him with ‘Sean Connery’. This was not ‘James Bond—007’, but the man himself, whom he described as being caring, compassionate, doing lots of charity work and making donations to the Children’s Ward at the Edinburgh Royal Infirmary, but was also someone he saw as cool, calm and confident and whom he aspired to be like in character.

**Phase Two (Sessions 6–8)—’Practising the Imagery Technique’**

Session 6

Jimmy was asked to recall memories of events from his childhood that he had found upsetting. He was then asked to close his eyes and imagine he was back in that situation, i.e. asked to describe ‘who was there? what were they doing? how they felt? who said what? how they felt?’. He was also asked to describe other aspects of the images elicited such as sights, sounds, smells, tastes, touch, which he thought were relevant. Jimmy identified a four year old boy (himself) cowering in a corner of the room sucking his thumb with his father hitting him repeatedly and shouting at him. He recalled feeling terrified and could not continue the imagery. He described the experience as ‘unlike anything he had tried before in therapy but the closest was perhaps hypnotism’.

Session 7

In the next session the therapist introduced the images of the four modes (Defenceless Jimmy, the Black Knight, the Hydra and Charles Darwin) into the imagery exercise and encouraged a dialogue between the four different modes. The Hydra (punitive parent—Jimmy felt that this was a combination of his brother and his Dad) was attacking the cowering little boy (vulnerable boy—Defence-
less Jimmy'). The Healthy Adult (Charles Darwin) was then introduced into the imagery. However, Jimmy's attempts to defeat the Hydra using the Healthy Adult did not progress very far and the Hydra remained strong and in control, continuing to attack the 'Vulnerable Child' mode.

**Example of Dialogue Between the Modes.**

**Defenceless Jimmy:** Ever since I can remember I have been plagued by anxiety and fear. They have made my life crumble around me again and again.

**Charles:** Why do you think this is happening to you over and over again?

**Defenceless Jimmy:** Because of my endless stream of failures at work, in relationships and in every aspect of my life.

**Charles:** Can this be blamed on anyone?

**Defenceless Jimmy:** Yes—it is the fault of parts of me, especially the Black Knight.

**Black Knight:** But I have protected you from being hurt all these years.

**Defenceless Jimmy:** Yes at a cost, and if you had been any good why do I still have all these problems?

**Charles:** Exactly. He doesn't seem much use. What has he been protecting you against?

**Defenceless Jimmy:** The Hydra!

**Hydra:** How dare you talk about me like this—you need teaching a lesson.

**Charles:** Leave him alone. This has gone on for long enough and it is going to stop.

**Hydra:** Oh yes, and how do you propose to do that?

**Session 8**

In this session the imagery technique was attempted again using a different memory. Jimmy used the image of him playing in the park and running up to his father and asking to play with him. At this point he broke down in tears but refused to tell the therapist the reasons for this, or what his father’s reply had been. He would only say that it made him (Defenceless Jimmy) feel that he was disgusting, worthless and unlovable. Jimmy then refused to do any more imagery (as his detached protector became the dominant mode?) and he began talking about ‘safe’ topics such as the recent change of his medication for the rest of the session.

**Phase Three (Sessions 9–11)—‘Bypassing the Detached Protector Mode’**

Clearly by the end of Session 8 the therapist had met with Jimmy’s resistance to engage further imagery exercises. In Session 9, Jimmy described the therapy as ‘silly’ and reported that it was ‘clearly not working’, and began to question whether or not the therapist really knew what he was doing. He insisted on discussing long passages of ‘safe’ topics from his diary, e.g. medication and jobs he had been doing around the house.

The therapist realized that Jimmy was continuing to be emotionally avoidant and helped him identify this as his ‘detached protector mode’. In this mode he was trying to sabotage therapy. Sessions 10 and 11 thus focused upon trying to convince Jimmy that although the detached protector ('the Black Knight') felt it was protecting the ‘vulnerable child’ (Defenceless Jimmy) from further abuse and hurt, this was not helping ‘Defenceless Jimmy’ recover in therapy. The aim of these two sessions was to try to convince ‘the Black Knight’ to allow the therapist past it and have access to Defenceless Jimmy again through imagery. A pros and cons exercise of staying in the detached protector mode was conducted and eventually the therapist was able to persuade Jimmy to continue with the imagery exercises and get back on course with the therapy.

**Phase 4 (Sessions 12–18)—‘Combating the Punitive Parent Mode’**

Imagery again was the main technique used here. Imagery of the dialogue between the Hydra, ‘Defenceless Jimmy’ and Charles Darwin continued. Unfortunately, Charles Darwin was not being very active in ‘doing battle’ with the Hydra and ‘Defenceless Jimmy’ was increasingly under attack. Something had to be done. Charles Darwin was replaced by Sean Connery (the ‘man’, not 007) and was much more successful in doing battle with the Hydra. To assist ‘Defenceless Jimmy’ in feeling safer a number of ‘flying harpies’ were introduced into the imagery. They were not modes but safety factors.
'Harpies' swooped down on the multi-headed hydra from different directions and attacked it. This made 'Defenceless Jimmy' feel a bit bolder and come out of the corner a little bit. The Healthy Adult (Sean Connery) also began to do a good job in verbally attacking and weakening the hydra by challenging its irrational thinking and bullying behaviours using traditional CBT techniques.

Session 14

‘Defenceless Jimmy’ was taking more risks in imagery and beginning to talk back and argue with the hydra. In doing so he was supported by the Healthy Adult and ‘Defenceless Jimmy’ felt he was ‘older’. He also reported feeling ‘stronger’ and ‘braver’ in himself and began to feel convinced that he was no longer so weak and frail as he once was. This was reflected in Jimmy’s activities outside the therapy room. He had begun going out of the house more, driving and going into shops (still accompanied by his mother). He also made contact with a few old classmates through the Internet on the ‘Friends Re-United’ website.

Sessions 15 and 16—‘Jimmy Contacts an Old Flame and Arranges a Date’

‘Defenceless Jimmy’ became more confident in the imagery sessions. Again this was reflected in his real life experiences. He arranged to meet an old female friend. In fact he did meet her. She came to stay with him and he had his first sexual contact since 1989. This in itself convinced Jimmy that he was not as frail and fragile as he had imagined and that his heart was strong, because he had handled the excitement. His girlfriend’s praise of him had also boosted his confidence.

Session 17—‘The Hydra’s Revenge’

Once Jimmy’s girlfriend had gone home the Hydra (punitive parent) came back at him, with a vengeance, attacking ‘Defenceless Jimmy’ (vulnerable child) strongly and viciously. He began to feel weaker, deflated and frightened again. He tried to get back into detached protector mode because his experiences in ‘Defenceless Jimmy’ mode were ‘too painful’, but he found that the ‘Black Knight’ had now fallen off his horse and was unable to get up. The Detached Protector was no longer there to protect him. He described this as his ‘false mask’ slipping and behind it was a ‘terrified little boy’. Imagery was used to help ‘Defenceless Jimmy’ feel safer again. Sean Connery (as the Healthy Adult) began to vigorously attack the hydra and many

'Harpies' were introduced to help in the attack. Eventually, Jimmy felt that the Punitive Parent mode (Hydra) had become weaker and ‘Defenceless Jimmy’ began to feel less frightened again.

An Example of Dialogue Between Modes.

Hydra: So you are feeling smug now eh? Well I will wipe that smile off your face you wretch. Don’t you realize she is playing you along? She is screwing someone else as we speak—imagine it Jimmy.

Defenceless Jimmy: I don’t believe that. She travelled on a 12000 mile round trip from America to see me. She told me she is very fond of me.

Hydra: Yes but now she has seen what a pathetic wimp you really are and how useless in bed you are, she is mocking your performance with her friends. You are useless and always will be.

Sean Connery: That’s enough! Jimmy, you can see what the hydra is doing. You are the one who she talks to for hours on end over the internet, she emails you everyday, she wants to see you again, she is serious about you. The hydra is jealous and angry with you because it knows that little by little it is losing control. It has no evidence to support its irrational and evil claims.

Hydra: Want to bet?

Defenceless Jimmy: Yes, for once in my life I do want to bet and if I am right I will know you are a fraud. For once you are not going to ruin things for me.

Sean Connery: Excellent, Jimmy—that’s the spirit!

Session 18—‘The Battle Rages—Combating the Punitive Parent (Hydra)’

Initially the punitive parent had been strong, irrational, unreasonable, spiteful and full of revenge. However, the therapist helped Jimmy to realize just how irrational and abnormal the punitive parent was. His own ‘failings’ were re-attributed back to the parent and Jimmy was helped to realize that it was normal for a child who had been exposed to such disturbed behaviour by a parent to be affected by it. He was also helped to realize how unreasonable it was for a parent to expect any positive feelings such as loyalty or to live up to the standards of such a bad parent. He
was taught to stand up to and fight the punitive parent, using the healthy adult mode (Sean Connery—the man not 007) to support him. At this point in therapy Jimmy felt stronger and reported that his vulnerable child was growing older and was about 10 years old now.

Phase 5 (Sessions 19 to 24)—‘Developing the Healthy Adult Mode Through Limited Re-Parenting’

This phase of therapy essentially involved the re-parenting of the vulnerable child by the Healthy Adult mode. The main techniques used were role play in imagery of the dialogue between the four modes identified and also the use of ‘acting imagery’ i.e. Jimmy imagining himself in different situations as Sean Connery (Healthy Adult) and imagining how Sean Connery might deal with everyday life events and situations. Jimmy then put into action in real life situations what he had been practicing in imagery. The main focus of this phase of therapy was to develop more healthy relationships and break self-defeating patterns of behaviour.

Session 21—Re-Introduction of Traditional Mainstream CBT Techniques

Jimmy began a systematic desensitization programme aimed at helping him overcome his phobic avoidance of driving, going into shops and crowded places and so on. At first he commenced the programme with his mother always being with him but as he progressed with the programme he began to do increasingly more of the tasks without his mother being present.

Sessions 22–24—‘Coming Out of a Frozen Wasteland After Three Decades’

Jimmy began to take more pride in his appearance and shaved of his beard, bought some new clothes, lost some weight and even took on some small-scale photographic jobs. He began to drive longer distances in his car and regularly visited shopping centres. Jimmy was by this time getting on very well with his new girlfriend whom he had met over the Internet. He described himself as coming out of a ‘frozen wasteland’ after decades. His mood states at this time were quite labile and vacillated between romantic, angry, anxious and depressed mood states fairly quickly. It was as if he were attempting to try and regulate emotions that he had previously been avoiding experiencing. He cried his first tears in a number of years.

Session 25—‘The Death of the Black Knight’

Jimmy reported that his detached protector (the ‘Black Knight’) was ‘dead’. The hydra (critical parent) was still alive but much weaker and Jimmy felt as if the vulnerable child (‘Defenceless Jimmy’) was now reaching ‘puberty’ and was on the ‘brink of something really good happening in his life’. At this time he met up with his girlfriend who was visiting England again. He described this as ‘crunch time’, and although he reported feeling terrified at the prospect of meeting her, he refused to cancel the date.

Session 26—‘The Sound of Wedding Bells’

Jimmy reported that he had got engaged to be married! He had also got rid of all his old letters and his old wedding ring from his first marriage and had thrown them all in the river. He described himself as feeling calmer in himself and more in control of his emotions. He was having lots of successes with his behavioural desensitization programme and was doing many more things on his own.

The Present Time . . . ‘Defenceless Jimmy Comes of Age’

Jimmy continues in therapy but is now able to come for therapy sessions unaccompanied. His girlfriend has moved to England and is now living with him. Jimmy now reports that he is a ‘healthy adult’. His vulnerable child he estimates is about 19 years old and no longer feels so vulnerable. He reports feeling like a different person and indeed he looks like a different person: having lost weight, shaved off his beard and bought new clothes. He still has a little way to go in overcoming all the targets in his desensitization hierarchy unaccompanied but feels much more confident he will go all the way and achieve them.

CLINICAL OUTCOME

As can be seen from Figure 3, there have been some very significant clinical reductions on most of Jimmy’s EMS scores (using the cut-off point of 3 as recommended by Young and Brown, 2001), when the pre and post scores were compared, with many of the post scores on zero (0%). The results support Young’s assertions outlined earlier in this paper (Young, 2001b) that Jimmy’s profile (i.e. the number and severity of EMSs) on the YSQ1 ‘pre’ questionnaire made him a suitable candidate for SMT and also supported the view that, even
though the patient did not fit the DSM IV classification for a borderline personality disorder, the approach used in SMT should be similar to that used for SMT for a borderline patient.

Interestingly, however, were some modest increases in the ‘enmeshment’ and ‘self-sacrifice’ schemas. Jimmy explained that he felt that this was due to these schemas becoming activated again after many years of being ‘dormant’. He felt that they had been activated by the fact that he was now in a relationship, whereas previously they had been inactive due to his avoidance of relationships, for many years prior to the course of SMT.

**DISCUSSION**

Schema Mode Therapy is a very new form of therapy, which is still in its infancy, and as for any new form of therapy there is obviously much research to be done to develop its evidence base. However, the results of this single case study are very encouraging and indicate that it may indeed be a very powerful form of therapy for certain types of complex case, for which more traditional approaches have been unsuccessful. The use of imagery did work well for Jimmy and appeared to be a particularly powerful technique for him to use. This technique did seem to produce profound change at an emotional level and assist the patient in the transition from knowing intellectually that his schemas were false to believing it emotionally. The technique did appear to turn ‘cold’ cognitions into ‘hot’ ones and assist Jimmy to more readily identify his core unmet emotional needs from childhood, through enabling him to feel his schemas and to understand how they began in childhood. With a little practice, Jimmy was able to use imagery and the techniques allowed positive healthy images to be introduced to counteract his negative ones. By developing a dialogue between the modes, Jimmy was able to begin the process of ‘re-parenting’. He was able to deepen his understanding of his problems and work on them using an SMT formulation in a way that he had not been able to do with previous therapies he had tried. The outcome of this case study does provide support for the view that EMSs can be modified to enable the individual to escape from their disabling ‘life-traps’ and that even schemas that are developed early in life, and are more at the core, can be changed.

There are of course other forms of therapy that focus on modifying core interpersonal schemas. Indeed, there are a number of theoretical models elaborated upon in the literature that it could be argued bear conceptual similarities to the mode concept. Alford and Beck (1997) propose that the schema concept may provide a common language to facilitate the integration of certain psychotherapeutic approaches. Some examples include...
Beck’s concept of modes (Beck, 1996), Ryle’s ‘multiple self states’ model (Ryle, 1997), Mair’s ‘community of self’ (Mair, 1977), Putnam’s ‘discrete behavioural states’ (Putnam, 1997a, 1997b), Horowitz’s ‘states of mind’ (Horowitz, 1979) and Freeman’s ‘scripts and lifestyles’ (Freeman, 1998).

In conclusion, SMT has some overlap with other theoretical models of psychotherapy, including psychodynamic models of therapy. So, what additional strengths does SMT have over and above these other approaches? Most of the other models are narrower in terms of the conceptual model or in terms of the range of treatment strategies used. There are also differences in terms of the therapy relationship adopted, the style of therapy, the level of directiveness of the therapist, how active the therapist is in the therapy and also in the ‘user friendliness’ of the therapy itself. SMT, as an extension of SFT, is a more practical, flexible, active, directive and user friendly form of therapy (for patients and therapists) than most other forms of therapy for treating patients with complex problems. It also incorporates many of the strengths of other therapeutic approaches but, in addition, has a greater range of clearly articulated treatment strategies to date than any other therapy used.

REFERENCES


Working with highly avoidant clients, a Schema Therapy approach – R Holt and R Younan

In order to get the most out of the workshop, prior to arriving, write a brief summary of a client who is challenging.

1. Presenting problem and symptoms:

2. Brief history:

3. What are the client’s main schemas?

4. What are the aspects of their presentation that you find difficult?

5. How does avoidance manifest outside of therapy and in therapy?

6. What does that bring up in you? What are the feelings, body sensations, thoughts and images that you have when you are finding them difficult to work with?