10

Schema Therapy for Cluster C Personality Disorders

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Introduction

Although Cluster C personality disorders (PDs) are usually seen as less severe than Cluster A and Cluster B PDs, they can be a real challenge for therapists. Patients' reliance on avoidance or control as primary safety strategies can be difficult to break through. These patients often stick to a passive patient role, demanding treatment without making the essential steps that are needed to recover. This chapter discusses a Schema Therapy (ST) approach for difficult Cluster C patients. The approach is partly based on earlier evidence that important aspects of ST are effective in this population (Weertman and Arntz, 2007) and partly on new insights into schema modes that are characteristic for these patients, and the kind of techniques they need to be successfully addressed in treatment. The order of the focus in treatment is based on preferences of patients and therapists in Weertman and Arntz (2007), but therapists and patients can choose their own order or mix.

Approach

Cluster C personality disorders and Schema Theory

Cluster C consists of three PDs: avoidant, dependent, and obsessive-compulsive. The common characteristic of these PDs is that anxiety dominates the functioning. Recent developments in ST for PDs focus more on *schema modes* than on *schemas*. Also with Cluster C PDs, the patients' complex problems are relatively easily understood in terms of schema modes and therapists can detect which modes are active during a session and apply techniques specifically developed for each one. Table 10.1 presents an overview of the most common modes in Cluster C PDs (Bamelis, Renner, Heidkamp and Arntz, 2011).

The Wiley-Blackwell Handbook of Schema Therapy: Theory, Research, and Practice, First Edition.
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Table 10.1 Overview of the most common schema modes in Cluster C PDs

Mode	*Description*
Coping Modes	
Avoidant Protector	Uses situational avoidance as survival strategy. Leads to loneliness, putting off decisions and important tasks, and an empty and boring life.
Detached Protector	Detaches from inner needs, emotions, and thoughts as a survival strategy. Although there might be interpersonal contact, there is lack of connection. The person feels empty.
Compliant Surrender	Complies with other people's wishes and suppresses own wishes as a survival strategy. This slave-like strategy might create inner resentment.
Perfectionistic Over-Controller	Uses excessive control and perfectionism as strategy to avoid making mistakes and/or feeling guilty for things that go wrong.
Self-Aggrandizer	Plays superior to compensate for inner feelings of inferiority, inadequacy, or doubt.
Child Modes	
Vulnerable Child	General term for any state in which the person feels like a little child with no help from other people that can be trusted to protect, nurture, and create safety. Includes the child modes listed below.
Abandoned/ Abused Child	State in which the person feels the abandonment or abuse experienced as a child again, or fears repetition of such experiences.
Lonely/Inferior Child	State in which the person feels the loneliness and/or inferiority experienced as a little child.
Dependent Child	State in which the person feels, thinks, and acts like a little child confronted with (practical) tasks the child does not know how to handle.
Internalized Parent Modes	
Punitive Parent	Internalization of punitive responses by parents/caretakers to needs, emotional expressions, assertiveness, autonomy. Usually leads to guilt feelings.
Demanding Parent	Internalization of high demands by parents/caretakers about productivity, perfectionism, social status, and moral issues. Not meeting the standards leads to feeling bad and ashamed.
Healthy Modes	
Healthy Adult	State in which the person takes care of him/herself and of other people in a healthy, mature way. Good balance between own needs and those of other people.
Happy Child	State in which the person is playful and joyful like a happy child. Is generally weak in Cluster C PDs.

Avoidant PD. In avoidant PD, anxiety is related to worries that other people find the person socially inept and inferior, but also that the patient does not have the capacity to deal with challenging situations in general. Avoidance is the dominant coping strategy – hence the name. That self-view is characterized by low self-esteem. Over the decades, the concept of avoidant PD has gradually changed from a personal-

ity characterized by fear of novelty and emotions, with the use of avoidance as a general coping strategy, to a personality characterized by these phenomena only in an interpersonal context. But arguments have been put forward that avoidant PD is characterized by avoidance not only in the social sphere and empirical findings support this (Arntz, 1999; Alden, Laposa, Taylor and Ryder, 2002; Taylor, Laposa and Alden, 2004; Bernstein, Arntz and Moll, in preparation). Thus, these people tend to avoid making decisions, 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. For ST this is an important finding, since it indicates that treatment should not only focus on social-phobic issues, but also deal with avoidance of a wide range of issues, notably emotions and risk-taking. Moreover, treatment should focus on low self-esteem, and views of the self as inadequate and inferior. Avoidant PD is associated with high levels of emotional abuse in childhood (Lobbestael *et al.*, 2010). Looking at parenting behaviors in a longitudinal study, Johnson and colleagues (2006) found evidence that lack of parental affection and nurturing was related to the development of avoidant PD (but also to six other PDs). Comorbid (recurrent) depression and dysthymia, anxiety disorders, and addiction are common.

A recent study by Bamelis and colleagues (2011) demonstrated that avoidant PD is characterized by specific modes (see Figure 10.1). Two coping modes are strongly present in avoidant PD: the Avoidant Protector and the Detached Protector. The Avoidant Protector is characterized by the use of situational avoidance; the Detached Protector mode is characterized by detaching from inner needs, feelings, and thoughts,

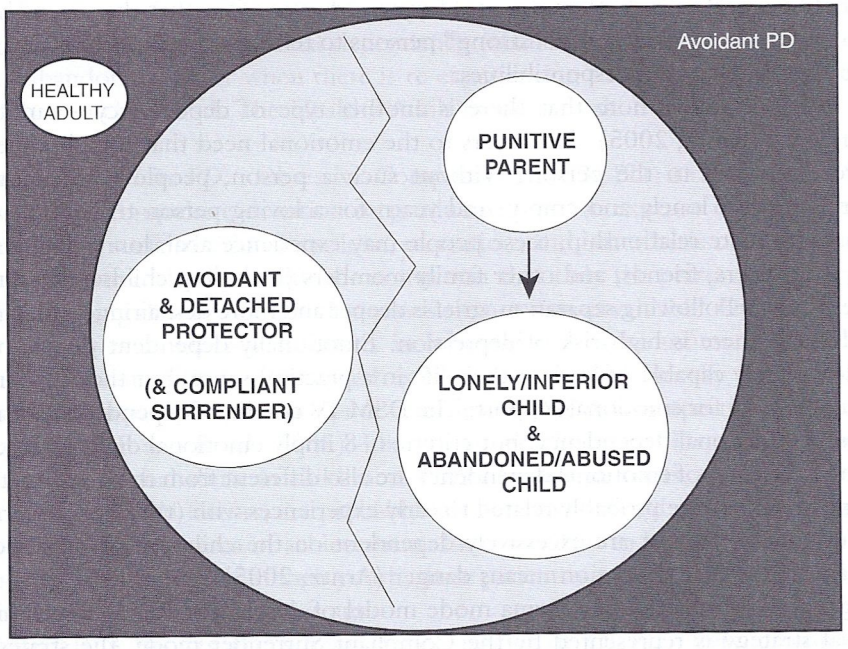

Figure 10.1 Schema mode model of avoidant personality disorder

and from emotionally connecting to other people. There might also be a Compliant Surrender coping mode, when patients tend to comply with other people's wishes. Second, a Punitive Parent mode is active, representing the internalization of emotionally abusive parenting experienced as a child. Third, at the core of the problem are the Lonely/Inferior Child and Abandoned/Abused Child modes. The Lonely/Inferior Child mode represents the emotional state these people try to avoid, in which they feel again the loneliness and inferiority they experienced as a child. The Abandoned/Abused Child mode represents the emotional state they experienced when they were abused or abandoned as a child. There is quite some overlap in modes with borderline PD (BPD), with BPD having additional Impulsive/Angry Child Modes and less Avoidant Protector mode.

Dependent PD. Dependent people worry about their capacities to lead an adult life. They feel incapable of making minor and major decisions and believe that they have to rely on a strong person to help them because they believe that they are not capable of running their life in *a practical sense*. Dependent people lack self-confidence and autonomy, have problems with taking adult responsibilities, and demand reassurance and support in practical areas from a strong helper. With a helper, they might seemingly function without problems, but problems may become very acute when this help threatens to stop or actually ceases. Because of the dependency focus on practical issues, it is helpful to label it as functional dependency (Arntz, 2005). The main specific etiological factor of dependent PD is authoritarian parenting, though overprotection may also play a role (Bornstein, 2005). Probably in interaction with a fearful makeup, children raised by authoritarian methods don't develop autonomy and trust in their own capacities to handle problems and make good choices. Childhood emotional abuse is also associated with dependent PD (Lobbestael, Arntz and Bernstein, 2010). As they were told over and over again that the parent knows best, they tend to turn to other "strong" persons to tell them what to think and what to do, and to take over responsibilities.

It is important to note that there is another type of dependency – emotional dependency (Arntz, 2005). This refers to the emotional need that somebody else is securely attached to the person. Without such a person, people with emotional dependency feel lonely and empty, and yearn for a loving person to connect with. With an intimate relationship, these people may experience abandonment fears and cling to partners, friends, and other family members (including children, leading to enmeshment). Following separation, grief is deeper and more despairing than in other people, and there is high risk of depression. Emotionally dependent people might feel completely capable of leading their life in a practical sense, but they desperately need somebody for emotional support. The DSM-IV criteria of dependent PD mainly represent functional dependency, but criteria 6–8 imply emotional dependency. The etiological factors of emotional dependency are also different from those of functional dependency: they are probably related to early experiences with (threat of) separation and/or to parents that are excessively dependent on the child. What these people have learned is that separation means danger (Arntz, 2005).

Figure 10.2 presents the schema mode model of dependent PD. The prominent survival strategy is represented by the Compliant Surrender mode, the strategy to comply with other people's opinions and requests, and to surrender to other people's

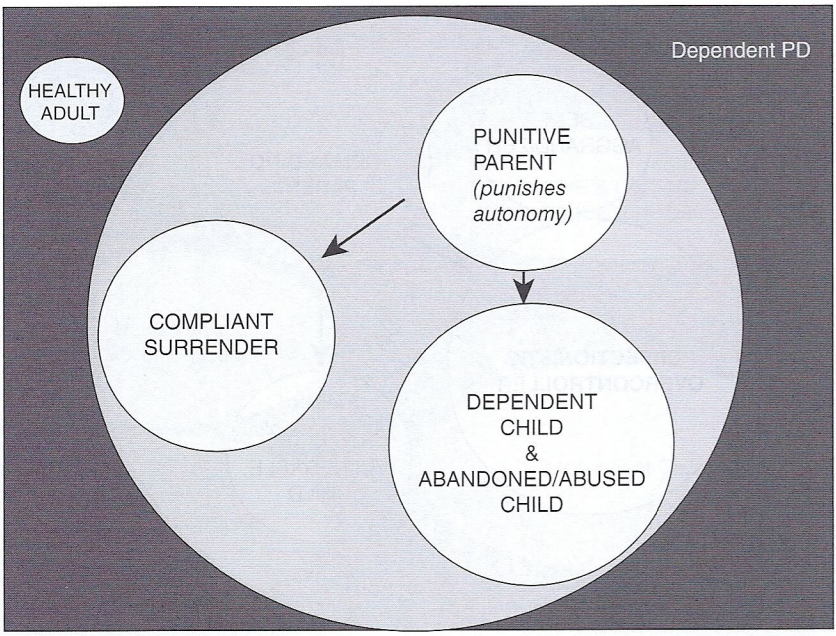

Figure 10.2 Schema mode model of dependent personality disorder

directions. There is an internalization of punitive responses by caretakers, notably those that punish autonomy, in the Punitive Parent mode. There is usually a strong Dependent Child mode, in which the patient feels overwhelmed by demands that adult life makes and will panic when others are not available or don't reassure them and take responsibility. There might also be an Abandoned/Abused Child mode, notably when there is emotional dependence (abandonment feelings and excessive fear of abandonment), or when there is re-experiencing of the emotional abuse that took place in childhood. The Healthy Adult mode is weak.

Obsessive-Compulsive PD. Obsessive-Compulsive PD (OCPD) is characterized by an excessive and compulsive devotion to productivity at the expense of other areas of life, including social relationships, love, recreation, and other basic needs. Standards are usually extremely high, with the conviction that only the person him/herself is capable of doing things correctly. Emotions are not seen as valuable. OC people often view themselves as superior to others in terms of conscientiousness, responsibility, and moral norms. Others are viewed as lazy, careless, and morally inferior. These views might be partly implicit, i.e., not directly available to introspection (Weertman, Arntz, de Jongh and Rinck, 2008). Like the other Cluster C PDs, OCPD is associated with emotional abuse in childhood. Other etiological roots, apart from genetic and other biological factors, are probably related to a cold and strict parenting with high standards in the area of achievement. Emotions had to be controlled and were considered of little worth. In their youth, these patients were often expected to accept too much responsibility for their age.

Figure 10.3 depicts the schema mode model of OCPD. Very prominent is the Perfectionistic Over-Controller mode, the survival strategy characterized by

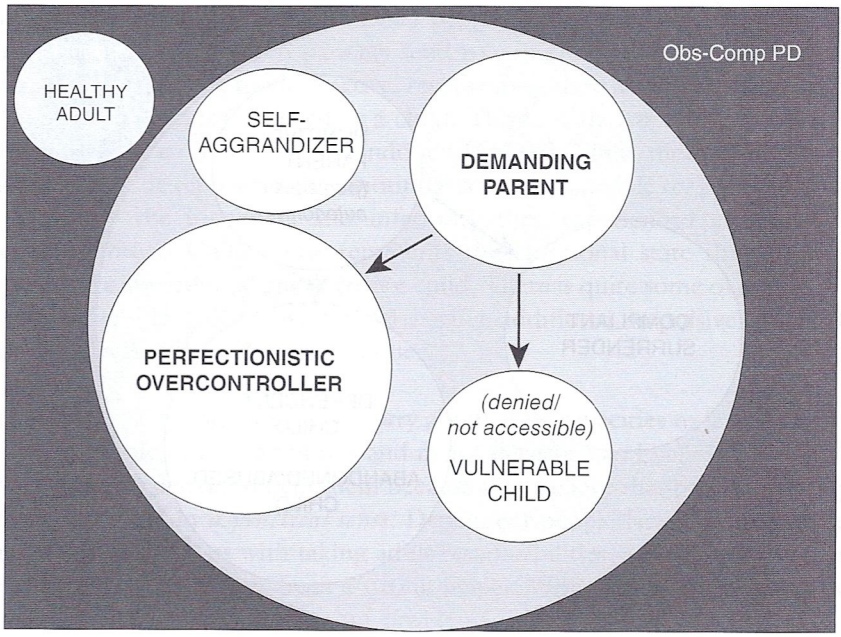

Figure 10.3 Schema mode model of obsessive-compulsive personality disorder

perfectionism and the excessive use of control. This coping mode is a direct response to the Demanding Parent. It represents the internalization of the high demands experienced as a child. Because OCPD people typically believe that others are careless and irresponsible, whereas they are capable of meeting the standards that should be met, they also have an element of the Self-Aggrandizer mode. OCPD patients usually deny (or cannot access) a Vulnerable Child mode. However, this mode usually emerges during therapy.

Case Conceptualization

Although we presented schema mode models for each Cluster C PD, for each individual patient a personalized mode model is made. Patients might differ slightly in the modes that are of importance for them. Knowledge of their PDs and PD traits can help in the formulation, but it is advisable to access other sources of information too: self-report questionnaires, clinical observations, diagnostic imagery exercises, anamnestics, and interviews. Figure 10.4 gives an example of an idiosyncratic mode model of a patient with OC and dependent PD. Two internalized parent modes, the Punitive and Demanding Parent modes, were chunked. This is recommended when modes are triggered at the same time and belong to one and the same category.

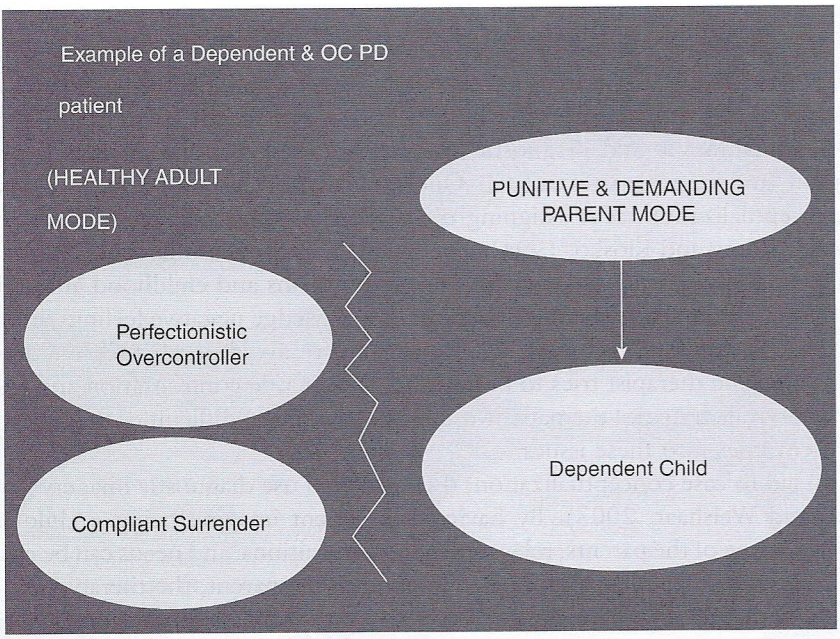

Figure 10.4 Idiosyncratic schema mode model of a patient with obsessive-compulsive and dependent personality disorder

Table 10.2 Overview of the phases in treatment

Year 1: 40 sessions
– Sessions 1–6: introduction, case conceptualization
– Sessions 7–24: focus on childhood memories
– Sessions 25-40: focus on present and behavioral change
Year 2: 10 booster sessions (± monthly)

Next, the conceptualization links modes to historical antecedents and present problems. This helps both patient and therapist understand the model, and organizes the problems to be addressed in therapy as they are now linked to modes (see Figure 10.5).

Treatment Approach

A general overview of the treatment is given in Table 10.2, describing a 50-session protocol. For educational purposes, the phases are described as more distinct than they need to be. The therapy might also be extended if necessary. The different phases will now be discussed, with the main foci and techniques of that phase.

Start of treatment: the first sessions

The first five to six sessions are devoted to getting acquainted with the patient, learning the patient's reasons for seeking therapy, learning what the patient hopes to obtain from ST, anamnestic and diagnostic interviewing, case conceptualization, psychoeducation, and an explanation of ST. Questionnaires are useful to help to make the case conceptualization, as is assigning the reading of some chapters of *Reinventing your Life* (Young and Klosko, 1994). The therapist introduces the concept of schema modes, and connects the modes with present problems and childhood antecedents.

Cluster C patients often find it difficult to acknowledge negative feelings, especially toward their parents. This might lead to attempts to avoid or to complete denial of these issues. The therapist tries to balance between gentle confrontation and respecting the survival strategies the patient uses to deal with the difficulties that arise when the patient goes into these issues.

As an aid to case conceptualization, therapists can use diagnostic imagery (Young, Klosko and Weishaar, 2003). By having the patient imagine being a child in the company of one of the parents, relevant feelings, cognitions, and needs can be clarified. If the patient has experienced severe traumas with the parent, the therapist can offer reassurance that traumatic memories should not be the topic of this diagnostic imagery.

The first phase ends with a case conceptualization, which is done in schema mode terms (see above). The therapist explains the mode concept and the origins of modes. A next step, in collaboration with the patient, is to connect the modes to the present problems. Axis I disorders are also related to modes. For instance, depression is often related to Detached and Avoidant Coping, Abandoned Child, and/or to Punitive Parent modes. The result of staying most of the time in an Avoidant/Detached Protector mode might be that life gets extremely boring, needs are not met, and depression follows as result of lack of positive experiences. Therapist and patient next try to understand how the modes developed in childhood. In other words, they relate the modes to experiences in childhood (Figure 10.5 gives an example). There is no need to strive for completeness (many aspects become clearer during treatment), but a general understanding helps patients to see their problems in perspective and prepares the ground for the treatment. Lastly, the therapist explains the general goals of therapy. In a nutshell, they are:

1. to help the child modes to develop and find safety, which is mainly achieved through emotional processing of (traumatic) childhood experiences, acknowledging needs and emotion of the little child, and corrective experiences in the treatment (limited reparenting);
2. to eliminate the punitive and demanding mode(s) as much as possible from the patient's system and replace them with healthy attitudes toward needs and emotions, and healthy standards and moral principles;
3. to let the healthy adult side develop, so that
4. the dysfunctional coping modes are less necessary.

Learning to recognize schema modes

Patients can fill out a diary to learn to recognize their schema modes in daily life. Therapist and patient discuss the diaries and can take one situation to work on further and address the problematic modes with one of the appropriate techniques.

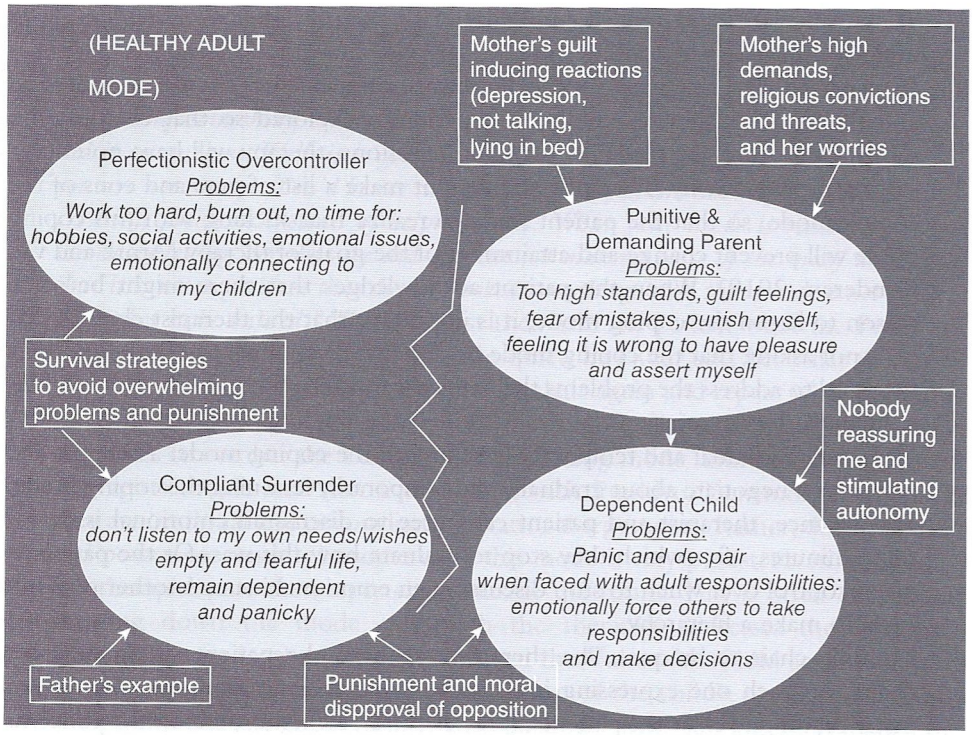

Figure 10.5 Historical antecendents and present problems placed in the schema mode case conceptualization (example)

During the session, the therapist can ask about changes in emotions and attitudes, and about a possible mode change. If the patient has no idea, the therapist can make a tentative suggestion and check with the patient to see if she/he agrees.

A typical session starts by asking the patient how she/he has been doing since the last session. The way the patient responds informs the therapist about the mode the patient is in, and the discussion will inform the therapist about emotional events that have taken place since the last session and what modes played a part. The therapist can then either continue with an important experience since the last session to focus on one or more specific modes, or focus on the mode that is active at that moment.

Setting the stage for the focus on childhood experiences

If Protector or Over-Compensator modes are very strong, they might block access of emotions and childhood memories related to emotions. In Cluster C patients, the Detached Protector mode might totally detach patients from emotions and childhood memories. In this mode, patients might claim that there is no use experiencing emotions and exploring childhood memories. The Perfectionistic Over-Controller might be very dominant in sessions, for instance when patients constantly correct the therapist for not exactly paraphrasing and summarizing what the patient said. The obsession with all the factual details distracts the patient from experiencing, and is therefore quite dysfunctional in treatment. In such cases, therapists might use a number of techniques to get the patient to get round these blockades.

1. Tentatively label the mode, empathize with it, and ask about the emotions underlying it.
2. Explanation. The therapist can explain that emotional issues should be addressed and their relationship to childhood experiences explored so that change on a schema level can take place. By avoiding emotions, therapy will have no effect.
3. Listing pros and cons. Therapist and patient make a list of pros and cons of the coping mode, so that the patient starts to realize that sticking with this coping mode will prevent change and attainment of the goals of therapy (Arntz and van Genderen, 2010). When the patient acknowledges that there might be some reason to lessen the coping mode, it is important that the therapist clarifies that he is not asking that the coping mode be completely eliminated, but temporarily bypassed to address the problems the patient wants help for. Usually, this method is followed by negotiation.
4. Negotiate a gradual and temporary lessening of the coping mode. Therapist and patient can negotiate about gradually and temporarily lessening the coping mode. For instance, therapist and patient can agree to discuss an emotional issue for three minutes, after which they stop to evaluate how this was. Or the patient is given control over when to stop discussing an emotional issue. Another possibility is to make a hierarchy.
5. Multiple chair technique. The therapist can have the patient sit on different chairs, on each one expressing ideas, needs, and feelings from one mode. For instance, on one chair the patient expresses the Detached Protector: the concerns of letting down the Detached Protector. On another chair the patient expresses the Vulnerable Child, for instance the need for real contact. On another the patient expresses the views of her Healthy Adult. The therapist can interview the different modes. At the end, the therapist might discuss with the Healthy Adult what is to be done.
6. Empathic confrontation. With this technique the therapist, on the one hand, empathizes with the intentions of the coping mode, and on the other, confronts the patient about the change that is needed.
7. Imagery. Sometimes the therapist can bypass a Detached Protector or Perfectionistic Over-Controller mode by just asking the patient to close the eyes and starting an imagery exercise. Imagery is related to a higher level of affect than talking and is therefore an effective technique to bypass obstructive coping modes.

Focus on childhood experiences

Fighting the Punitive and Demanding Parent modes. When the Punitive or Demanding Parent mode is very active during the session, or has played a major role in a recent problem, the therapist combats it. The most important methods, as in ST of BPD (Arntz and van Genderen, 2010), are:

1. Empty chair technique. The therapist asks the patient to sit on another chair and to express what the mode is saying. The patient should be instructed to say "you" rather than "I," for example: *"you have failed and it is your fault; you are guilty."* Next the patient returns to the original chair. The therapist then talks to the

mode on the empty chair as if it is a person, clearly disagreeing: *"It is not true that Jane failed, and it is not her fault. She just overlooked a sentence when she typed her boss's messy notes. You cannot use such words for this. First, nobody is perfect and overlooking something is human. Second, saying that she is guilty implies that she did it on purpose. Well, it is obvious she didn't overlook the sentence on purpose. So you are not correct. You'd better stay out of this as you are not helping. You are only creating problems instead of helping Jane. What Jane needs is reassurance and somebody telling her that she did a great job making sense of the messy notes, and that it is not a problem that she overlooked something, and that she does not need to be perfect to be valued."* The therapist then asks the patient what the Punitive/Demanding mode is saying. If it is not quiet, he either asks her what the mode is saying, or asks the patient to sit on the chair again and repeat what the mode is saying, after which the patient returns to the original chair. The therapist continues to combat the Punitive or Demanding mode until the mode is quiet. Therapists should not start a discussion with Punitive/Demanding modes, as they are irrational and unconvinced by rational arguments. Rather, determination and power are central. In some cases this mode is very persistent, in which case the therapist puts the empty chair outside the room. This is often effective in shutting down the mode. Although the therapist addresses the Punitive/Demanding mode, the Healthy Adult and the Vulnerable Child are listening. It is therefore important to weave in validation of the child's needs and feelings, and psycho-educate about healthy and functional attitudes. Later in therapy, the patient starts to combat the Punitive/Demanding mode him/herself, either from a (Angry) Child perspective, or from the Healthy Adult mode. The therapist coaches and simulates getting angry, something that can be difficult for Cluster C PD patients.

2. Imagery rescripting. The therapist asks the patient to close their eyes, evoke an image of a recent situation where the Punitive or Demanding Parent mode was active, and experience the mode again. Next, the therapist asks the patient to let the image go but stay with the feelings, and instructs him/her to see whether an image from childhood pops up. Alternatively, the therapist asks the patient to close their eyes and directly get an image of the parent that was punitive, critical, or demanding. After the patient has experienced what the parent's behavior evoked in the Vulnerable Child, the therapist steps into the scene and intervenes by talking to the parent and telling him/her to stop, as with the empty chair technique (see Arntz and Weertman, 1999; Arntz and van Genderen, 2010; Arntz, 2011).
3. Psycho-education. Many Cluster C patients have dysfunctional views of (children's) needs, emotions, guilt, and shame. For instance, they might think that they need a Demanding mode because without it they wouldn't get anything done. Psycho-education helps to distance them from these internalized dysfunctional high and punitive standards. Special care should be taken to explain issues such as indirect guilt-induction (e.g., the mother lying depressed in bed and not talking to the child for days in reaction to the child's "bad" behavior), negative loyalty (enforcing loyalty and obedience by threatening the child, in contrast to healthy positive loyalty, where the child is loyal because it gets positive things such as love and protection from the parents), and intergenerational transmission of punitive and demanding attitudes.

4. Letter writing. Patients can write a letter to their parents, telling them what their demanding, critical, and punitive behavior meant for them when they were a child and how it still influences their lives. Don't let them send the letter until a plan has been set out of how to deal with possible negative reactions from the parents or other family members. This technique primarily aims at stimulating expression of feelings and opinions, and creating a distance from the negative parental influences.

Taking care of the Vulnerable Child modes

The Vulnerable Child modes consist of the Abandoned/Abused Child, the Dependent Child, and the Lonely Child modes. It is important that attention is given to these modes, especially during the early phases of treatment. In summary, the techniques are as follows:

1. Care and validation through limited reparenting. Through limited reparenting, therapists offer validation of the needs and feelings that patients experience from their Vulnerable Child modes. Safety to express emotions and needs during the therapy is essential to meet the core needs of the Vulnerable Child and to correct unsafe attachment and emotional abuse that is characteristic of Cluster C patients. Thus, if during a session primary emotions are accessed, the therapist is empathic and validating, and reassures the patient that it is OK to have and express these emotions. This is especially important with sadness, since many Cluster C patients are extremely afraid of sadness and are rather depressed or suffer from somatoform complaints rather than feeling sad (and angry).
2. Imagery rescripting. In this technique, an image of a childhood memory is "rescripted" by having an adult enter the scene and intervening, thus changing the script. In Cluster C patients, it is advisable that initially the therapist does the rescripting. Most Cluster C patients have not received real care as a child and they should learn, on the child level so to say, to receive and accept care. The following approach is suggested.
   a. A problem experienced during the last week is identified (or a feeling emerging during the session).
   b. The patient closes the eyes and imagines the recent problem. The patient describes in here-and-now terms, from his/her own perspective, what happens and what he/she experiences and needs.
   c. The feeling and the experienced needs are used for an "affect bridge" to retrieve a (traumatic) memory from childhood.
   d. The patient describes the scene in here-and-now terms, from the viewpoint of the Vulnerable Child, and experiences feelings and needs. If severe abuse is near, the therapist doesn't wait to intervene.
   e. The therapist tells the patient that he/she is entering the scene and describes how he/she is acting to correct what is happening. The patient might protest (patients often avoid or subordinate, and might want therapists to do the same), but therapists have to trust that what they do is OK. If there is abuse or threat of abuse, therapists stop or prevent it. The patient describes what happens next in the image, and how he/she feels then, and what he/she

needs. Rescripting continues until the threat is under control. Then the therapist takes care of the Vulnerable Child. Often the child needs to be soothed.

f. After imagery rescripting the exercise is discussed. The patient is asked to listen to the recording and to repeat the whole exercise at home.

g. If the patient is not satisfied, other ways of rescripting are tried. Patients are invited to develop variations that are tried out. Extended discussion and examples can be found in Arntz (2010), Arntz and van Genderen (2010), and Arntz and Weertman (1999).

3. Historical role-play. With this technique, situations from childhood are enacted rather than imagined. Usually it begins with the patient playing the child and the therapist the other person, often one of the parents. The technique can be used to elicit emotions and clarify childhood situations, but also to change perspectives and to rescript memories. Role-switching can be used, that is to say, after an initial round the patient now plays the other person and the therapist the child. Therapist and patient can discuss how the patient experienced the situation from the perspective of the parent, which sometimes leads to a change in interpretation of the parent's behavior (e.g., the patient discovers that the parent was depressed and tired, leading to neglecting the needs of the child, but not not-loving the child). Rescripting can be done by having the therapist or the patient as an adult enter the scene, address the parent, and take care of the Vulnerable Child. Historical role-play is less suitable for physical and sexual abuse, as these cannot (for obvious reasons) be played out. The technique is more fully described in Arntz and Weertman (1999) and Arntz and van Genderen (2010).
4. Stimulating and teaching the patient to get basic needs better met. During treatment therapists help patients to recognize their needs better, and encourage them to get these better met. Although some of the unmet childhood needs cannot be fully repaired in adulthood, this does not imply that related needs cannot be met on an adult level. In general this implies that patients have to change how they handle their personal relationships, work, and spare time.

Focus on change in the present

Especially in the second half of treatment, the focus is increasingly focused on the present and on behavioral change. Therapists should not expect that patients will easily change their behavior as a result of intellectual and emotional insight gained in the previous phase of therapy. Cluster C patients especially are often seemingly addicted to the short-term effects of their coping modes, the emotion-avoiding effects of avoidance, detachment, submission, or perfectionism and control. If patients avoid asserting themselves, but complain about being mistreated and feeling tired, the therapist gently but firmly motivates the patient to try out healthy assertiveness. All kinds of behavioral techniques can be used. Some of the specific ST techniques in this phase are:

1. Multiple chair technique. The therapist can ask the patient to express the different modes that play a role on different chairs. Finally, the Healthy Adult is asked

to express what he/she thinks of the whole situation and what should be done. The therapist can discuss with the Healthy Adult what are good strategies to handle the situation and what can be tried out.

2. Mode diary. The patient fills out a diary about a difficult situation in which he reports which modes were activated and what these modes felt and thought about it. He can then challenge dysfunctional views and try to formulate a healthy view (and try out healthy behavior).
3. Flash card. Patient and therapist make a flash card that can help the patient to deal in a more functional way with difficult situations. On one side, the typical trigger and the triggered mode with its feelings, thoughts, and behaviors is written. On the other side, the Healthy Adult view is written including reality testing if indicated (e.g., pointing out that triggered feelings are more related to situations from the past than to the present) and healthy behavior is described.
4. Role-plays. The patient can try out new behaviors in role-plays. The therapist can model different variants.
5. Empathic confrontation. This technique is mainly used for dysfunctional coping modes. A good empathic confrontation relates the dysfunctional behavior to a mode, empathizes with the mode's function, and relates this to its childhood origins, then clarifies what is different between the present and the childhood situation, and pushes for change in a validating way (e.g., "You, like everybody else, have the fundamental right to express your opinion").
6. Imagery rescripting. Imagery rescripting can also be used to rescript future situations. First, the patient imagines the future situation, which usually leads to uncomfortable feelings that are raised again. This is then related to a mode that is triggered. Next the therapist asks the patient to switch to the Healthy Adult mode and imagine handling the situation from that mode. When needed, the therapist enters the image and coaches the patient. Imagery rescripting with difficult situations in the present or future can be very empowering.
7. Teaching healthy attitudes. Patients might lack knowledge about healthy attitudes and behaviors. Teaching them can be important.
8. Push toward healthy choices. Some patients have become trapped in unhealthy situations because they made the wrong choices due to their PD pathology. Some need to be pushed to make healthy choices to overcome their problems. For instance, if abusive partners or bosses cannot be changed, patients would do better to leave them. Patients might find this very difficult or frightening, and the therapist should support them emotionally.
9. Focus on the therapeutic relationship. If the patient behaves in a dysfunctional way in the therapeutic relationship, the therapist should gently point this out, discuss what modes are underlying it, and help the patient to find a healthy way to relate to the therapist.

Techniques focusing on childhood situations can be combined with techniques focusing on the present. Trying to make changes in the present can trigger strong emotions related to childhood memories, and it may be appropriate to address them, for instance, with imagery rescripting. After addressing childhood memories, an explicit connection to the present is made and the need for behavioral change is discussed.

Booster sessions

At the end, booster sessions are offered. One possibility would be to offer a monthly booster session for a year, but other intervals are conceivable.

The aim is that patients try out life without intensive therapy, without abruptly breaking off the positive influence of therapy. Patients are well prepared for these booster sessions. Booster sessions are real therapy sessions, not just a chat. Thus, all techniques can be used, even imagery of childhood events (as patients might come with new, unprocessed memories). A typical approach would be to ask the patient how (s)he has been doing since the last session, and if the patient reports any problems or relapse that the patient has not successfully addressed him/herself, patient and therapist try to find what modes were related to it. Usually, more and more responsibility is given to the patient to promote the development of skills and habits to detect and correct dysfunctional modes.

In using ST techniques, patients' Healthy Adult parts are given the lead more and more. For instance, in imagery rescripting of childhood memories the Healthy Adult part of the patient rescripts.

Whilst some patients quite rapidly find this phase is therapeutic, others can resist it for quite some time. We have learned that many responded to the gradual withdrawal of the therapist with seeming relapses, complaining that they had not changed or even accusing the therapist of maltreating them. But we also learned that in the end, these patients realized that therapists cannot rescue them and that they had to make a decision: either to return to old patterns or to act on what they learned in therapy. Framing the difficulties that are often presented by these patients as if they are helpless victims as *choices* is important here. Thus, the therapist should point out, once the modes are clear, that the Healthy Adult can make a decision: to use the old coping strategies (e.g., the Avoidant Protector) or use a new functional strategy, even when it makes them fearful. Therapists gradually reduce their motivational and pushing attitude, and gently hand over the choice to the patient.

Pitfalls and Tips: Specific Issues with the Different Cluster C PDs

Boxes 10.1–10.3 give an overview of the specific issues that are relevant in the treatment of avoidant, dependent, obsessive-compulsive PD. These issues may help the therapist to treat these patients and to adapt ST to what they need.

Discussion

A ST approach for the three Cluster C PDs based on schema mode models was discussed. The reader should realize that ST for Cluster C PD has only recently been developed and the empirical evidence for its effectiveness is still limited. Weertman and Arntz (2007) suggested strong effects of the major ingredients of ST for Cluster C PDs, and high effect sizes for the total package (Cohen's d was about 1.5). But this study was not a comparison of different treatments. A large, multicenter RCT

Box 10.1 Specific issues with avoidant PD

At start: focus on avoidance of experiencing needs and emotions
Fight Punitive Parent and correct low self-esteem (e.g., by imagery rescripting)
Push to less avoidance of:
- Feeling
- Social contacts and roles
- Intimacy
- Making choices
- Having opinions and expressing them

Be aware of alcohol, drugs, medication abuse, and addiction: many of these patients would rather abuse substances than feel emotions.
Address how to deal with conflicts and irritation.

Box 10.2 Specific issues with dependent PD

Correct authoritarian parenting
Push to express own opinions and emotions
Push autonomy
Don't allow patient to submit to you and make you an authority (be aware of your own schemas)
Teach how to have disagreements.

Note: this reparenting is a bit different from many other PDs (don't promote dependence, but independence). Gets complicated when there is both a Dependent and an Abandoned Child mode. Try to decide for yourself whether the patient needs *emotional* connection and safety, or tries to get *practical* help, or tries to make you responsible.

Box 10.3 Specific issues with obsessive-compulsive PD

Get rid of Demanding Parent mode
Ask patient to reduce the Perfectionistic Over-Controller
Explain and push for importance of emotions, intimacy, and social contacts
Let patient experiment with imperfection.

that compared ST to treatment as usual (TAU) and to an interesting psychotherapeutic alternative, client-centered therapy according to Sachse (2001), was recently completed but final data are not yet available.

Meanwhile, clinical and empirical observations indicate that ST is not a panacea for all Cluster C patients. In the RCT mentioned above, drop out from treatment was significantly lower in ST than in TAU conditions, but was still 25% over two years. In-depth interviews with ST patients indicated that, at least in the early phases, patients found imagery very difficult and confrontational (ten Napel-Schutz *et al.*, 2011). An extended explanation of experiential techniques might help, but fear of emotions and reliance on avoidant and controlling survival strategies probably remain a problem.

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References

Alden, L.E., Laposa, J.M., Taylor, C.T. and Ryder, A.G. (2002) Avoidant personality disorder: current status and future directions. *Journal of Personality Disorders*, *16*, 1–29.

Arntz, A. (1999) Do personality disorders exist? On the validity of the concept and its cognitive-behavioural formulation and treatment. *Behaviour Research and Therapy*, *37*, S97–S134.

Arntz, A. (2005) Pathological dependency: distinguishing functional from emotional dependency. *Clinical Psychology: Science and Practice*, *12*, 411–416.

Arntz. A. (2010) Schematherapie bei Cluster C Persönlichkeitsstörungen, in *Fortschritte der Schematherapie, Konzepte and Anwendungen* (eds E. Roediger and G. Jacob). Göttingen: Hogrefe-Verlag, pp. 146–182.

Arntz. A. (2011) Imagery rescripting for personality disorders. *Cognitive and Behavioral Practice*, *18*, 466–481.

Arntz, A. and Genderen, H. van (2010) *Schematherapie bei Borderline-Persönlichkeitsstörung*. Weinheim: Beltz.

Arntz, A. and Weertman, A. (1999) Treatment of childhood memories; theory and practice. *Behaviour Research and Therapy*, *37*, 8, 715–740.

Bamelis, L.L.M., Renner, F., Heidkamp, D. and Arntz, A. (2011) Extended schema mode conceptualizations for specific personality disorders: an empirical study. *Journal of Personality Disorders*, *25*(1), 41–58.

Bornstein, R.F. (2005) *The Dependent Patient: a Practitioner's Guide*. Washington, DC: American Psychological Association.

Johnson, J.G., Cohen, P., Chen, H., Kasen, S. and Brooks, J.S. (2006) Parenting behaviors associated with the risk for offspring personality disorder during adulthood. *Archives of General Psychiatry*, *63*, 579–587.

Lobbestael, J., Arntz, A. and Bernstein, D.P. (2010) Disentangling the relationship between different types of childhood maltreatment and personality disorders. *Journal of Personality Disorders*, *24*, 285–295.

Napel-Schutz, M.C. ten, Abma, T.A., Bamelis, L. and Arntz, A. (2011). Personality disorder patients' perspectives on the introduction of imagery within Schema Therapy: a qualitative study of patients' experiences. *Cognitive and Behavioral Practice*, *18*, 482–490.

Sachse, R. (2001) *Psychologische Psychotherapie der Persönlichkeitsstörungen*. Göttingen: Hogrefe.

Taylor, C.T., Laposa, J.M. and Alden, L.E. (2004) Is avoidant personality disorder more than just social avoidance? *Journal of Personality Disorders*, *18*, 571–594.

Weertman, A. and Arntz, A. (2007) Effectiveness of treatment of childhood memories in cognitive therapy for personality disorders: a controlled study contrasting methods focusing on the present and methods focusing on childhood memories. *Behaviour Research and Therapy*, *45*, 2133–2143.

Weertman, A., Arntz, A., de Jong, P.J. and Rinck, M. (2008) Implicit self- and other-associations in obsessive-compulsive personality disorder traits. *Cognition and Emotion*, *22*, 1253–1275.

Young, J.E. (1999) *Cognitive Therapy for Personality Disorders: a Schema-focused Approach*, revised edition. Sarasota, Fl.: Professional Resource Press.

Young, J.E. and Klosko, J.S. (1994) *Reinventing Your Life*. New York: Plume.

Young, J.E., Klosko, J.S. and Weishaar, M.E. (2003) *Schema Therapy: a Practitioner's Guide*. New York: Guilford Press.