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# Series Preface

*Tony Rousmaniere and Alexandre Vaz*

We are pleased to introduce the Essentials of Deliberate Practice series of training books. We are developing this book series to address a specific need that we see in many psychology training programs. The issue can be illustrated by the training experiences of Mary, a hypothetical second-year graduate school trainee. Mary has learned a lot about mental health theory, research, and psychotherapy techniques. Mary is a dedicated student; she has read dozens of textbooks, has written excellent papers about psychotherapy, and receives near-perfect scores on her course exams. However, when Mary sits with her clients at her practicum site, she often has trouble performing the therapy skills that she can write and talk about so clearly. Furthermore, Mary has noticed herself getting anxious when her clients express strong reactions, such as getting very emotional, hopeless, or skeptical about therapy. Sometimes this anxiety is strong enough to make Mary freeze at key moments, limiting her ability to help those clients.

During her weekly individual and group supervision, Mary's supervisor gives her advice informed by empirically supported therapies and common factor methods. The supervisor often supplements that advice by leading Mary through role-plays, recommending additional reading, or providing examples from her own work with clients. Mary, a dedicated supervisee who shares tapes of her sessions with her supervisor, is open about her challenges, carefully writes down her supervisor's advice, and reads the suggested readings. However, when Mary sits back down with her clients, she often finds that her new knowledge seems to have flown out of her head, and she is unable to enact her supervisor's advice. Mary finds this problem to be particularly acute with the clients who are emotionally evocative.

Mary's supervisor, who has received formal training in supervision, uses supervisory best practices, including the use of video to review supervisees' work. She would rate Mary's overall competence level as consistent with expectations for a trainee at Mary's developmental level. But even though Mary's overall progress is positive, she experiences some recurring problems in her work. This is true even though the supervisor is confident that she and Mary have identified the changes that Mary should make in her work.

The problem with which Mary and her supervisor are wrestling—the disconnect between her knowledge about psychotherapy and her ability to reliably perform psychotherapy—is the focus of this book series. We started this series because most therapists experience this disconnect, to one degree or another, whether they are beginning trainees or highly experienced clinicians. In truth, we are all Mary.

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To address this problem, we are focusing this series on the use of deliberate practice, a method of training specifically designed for improving reliable performance of complex skills in challenging work environments (Rousmaniere, 2016, 2019; Rousmaniere et al., 2017). Deliberate practice entails experiential, repeated training with a particular skill until it becomes automatic. In the context of psychotherapy, this involves two trainees role-playing as a client and a therapist, switching roles every so often, under the guidance of a supervisor. The trainee playing the therapist reacts to client statements, ranging in difficulty from beginner to intermediate to advanced, with improvised responses that reflect fundamental therapeutic skills.

To create these books, we approached leading trainers and researchers of major therapy models with these simple instructions: Identify 10 to 12 essential skills for your therapy model where trainees often experience a disconnect between cognitive knowledge and performance ability—in other words, skills that trainees could write a good paper about but often have challenges performing, especially with challenging clients. We then collaborated with the authors to create deliberate practice exercises specifically designed to improve reliable performance of these skills and overall responsive treatment (Hatcher, 2015; Stiles et al., 1998; Stiles & Horvath, 2017). Finally, we rigorously tested these exercises with trainees and trainers at multiple sites around the world and refined them based on extensive feedback.

Each book in this series focuses on a specific therapy model, but readers will notice that most exercises in these books touch on common factor variables and facilitative interpersonal skills that researchers have identified as having the most impact on client outcome, such as empathy, verbal fluency, emotional expression, persuasiveness, and problem focus (e.g., Anderson et al., 2009; Norcross et al., 2019). Thus, the exercises in every book should help with a broad range of clients. Despite the specific theoretical model(s) from which therapists work, most therapists place a strong emphasis on pantheoretical elements of the therapeutic relationship, many of which have robust empirical support as correlates or mechanisms of client improvement (e.g., Norcross et al., 2019). We also recognize that therapy models have already-established training programs with rich histories, so we present deliberate practice not as a replacement but as an adaptable, transtheoretical training method that can be integrated into these existing programs to improve skill retention and help ensure basic competency.

## About This Book

This book is focused on schema therapy, an approach that evolved from the work of Jeffrey Young and others with a focus on more effectively treating clients with personality disorders and those with chronic symptom profiles who failed to respond to or relapsed after traditional cognitive behavioral therapy (Arntz, 1994; Behary, 2008, 2021; Farrell et al., 2014; Farrell & Shaw, 1994, 2012; Young, 1990; Young et al., 2003). Young's theoretical–conceptual framework originally focused on individual therapy (Young, 1990; Young et al., 2003) and was later adapted to also work with couples, groups, and children and adolescents. Schema therapy is a comprehensive, clear, and robust theoretical model—one that strategically selects and integrates strategies from other psychotherapy schools of thought, such as cognitive behavioral, gestalt, and emotion-focused therapies; eye movement desensitization and reprocessing; mindfulness; interpersonal neurobiology; and somatosensory interventions.

Our goal with this book is for deliberate practice to be an additional piece designed to enhance schema therapy training. Ideally, deliberate practice can help trainees and

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therapists integrate essential schema therapy skills into their repertoire, allowing access to them in an automatic fashion in response to the client context. The skills set forth in this book are the basic skills; they are not intended to be comprehensive. Deliberate practice is not intended to be the only training format through which schema therapy competency is acquired. It is best viewed as an important new complement to other training and supervision methods.

Thank you for including us in your journey toward psychotherapy expertise. Now let's get to practice!

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CHAPTER 1

# Introduction and Overview of Deliberate Practice and Schema Therapy

My (W. B.) personal exposure to schema therapy (ST) began with the privilege of learning and working alongside Jeff Young, and other colleagues, in the early development of the model. There was discussion, experimentation, and procedural attention paid to theory, conceptualization, treatment formulation, and application. Deliberate practice, with its targeted microskills learning, would have added value to training competent ST practitioners. In this book, we want to fill this common gap in therapists' procedural training. The focused attention that deliberate practice pays to breaking down complex interventions into small parts offers clinicians the opportunity to practice skills carefully in the context of specific problems. Repetitive practice, so often missing in psychotherapy training, is a prerequisite to developing professional expertise and flexibility in many other fields. In learning tennis, focused attention must go into experiencing each part of the execution: posture, grip, footing, timing, eye contact, and follow-through. Then it's practice, practice, practice. Eventually, the relationship with the racquet in hand and your placement on the court is formed. Much in the same way, we believe that mindfulness and deliberate skills practice are necessary elements to develop competent schema therapists.

## Overview of the Deliberate Practice Exercises

The main focus of the book is a series of 14 exercises that have been thoroughly tested by an international community of ST trainers and trainees. Each of the first 12 exercises represents an essential ST skill. The last two exercises are more comprehensive, consisting of an annotated ST transcript and improvised mock therapy sessions that teach practitioners how to integrate all these skills into more expansive clinical scenarios. Table 1.1 presents the 12 skills that are covered in these exercises.

Throughout all the exercises, trainees work in pairs under the guidance of a supervisor and role-play as a client and a therapist, switching back and forth between the two roles. Each of the 12 skill-focused exercises consists of multiple client statements grouped by

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**TABLE 1.1. The 12 Schema Therapy Skills Presented in the Deliberate Practice Exercises**

| Beginner Skills | Intermediate Skills | Advanced Skills |
|---|---|---|
| 1. Understanding and attunement<br>2. Supporting and strengthening the healthy adult mode<br>3. Schema education: beginning to understand current problems in schema therapy terms<br>4. Linking unmet needs, schema, and presenting problem | 5. Education about maladaptive schema modes<br>6. Recognizing the mode shifts of the maladaptive coping modes<br>7. Identifying the presence of the demanding/punitive inner critic mode<br>8. Identifying the presence of the angry and vulnerable child modes | 9. Limited reparenting for the angry and vulnerable child modes<br>10. Limited reparenting for the demanding/punitive inner critic mode<br>11. Limited reparenting for the maladaptive coping modes: empathic confrontation<br>12. Implementing behavioral pattern breaking through homework assignments |

difficulty—beginner, intermediate, and advanced—that calls for a specific skill. For each skill, trainees are asked to read through and absorb the description of the skill, its criteria, and some examples of it. The trainee playing the client then reads the statements. The trainee playing the therapist then responds in a way that demonstrates the appropriate skill. Trainee therapists will have the option of practicing a response using the one supplied in the exercise or immediately improvising and supplying their own.

After each client statement and therapist response couplet is practiced several times, the trainees will stop to receive feedback from the supervisor. Guided by the supervisor, the trainees will be instructed to try statement–response couplets several times, working their way down the list. In consultation with the supervisor, trainees will go through the exercises, starting with the least challenging and moving through to more advanced levels. The triad (supervisor–client–therapist) will have the opportunity to discuss whether exercises present too much or too little challenge and adjust up or down depending on the assessment.

Trainees, in consultation with supervisors, can decide which skills they wish to work on and for how long. On the basis of our testing experience, we have found that, to receive maximum benefit, practice sessions should last about 1 to 1.25 hours. After this, trainees become saturated and need a break.

Ideally, ST learners will both gain confidence and achieve competence through practicing these exercises. *Competence* is defined here as the ability to perform an ST skill in a manner that is flexible and responsive to the client. Skills have been chosen that are considered essential to ST and that practitioners often find challenging to implement.

The skills identified in this book are not comprehensive in the sense of representing all one needs to learn to become a competent ST clinician. Some will present particular challenges for trainees.

## The Goals of This Book

The primary goal of this book is to help trainees achieve competence in core ST skills. Therefore, the expression of that skill or competency may look somewhat different across clients or even within session with the same client.

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The deliberate practice exercises are designed to accomplish the following:

1. Help schema therapists develop the ability to apply the skills in a range of clinical situations.
2. Move the skills into procedural memory (Squire, 2004) so that schema therapists can access them even when they are tired, stressed, overwhelmed, or discouraged.
3. Provide schema-therapists-in-training with an opportunity to exercise skills using a style and language that is congruent with who they are.
4. Provide the opportunity to use the ST skills in response to varying client statements and affect. This is designed to build confidence to adopt skills in a broad range of circumstances within different client contexts.
5. Provide schema therapists in training with many opportunities to fail and then correct their failed response based on feedback. This helps build confidence and persistence.

Finally, this book aims to help trainees discover their own personal learning style so they can continue their professional development long after their formal training is concluded.

## Who Can Benefit From This Book?

This book is designed to be used in multiple contexts, including in graduate-level courses, supervision, postgraduate training, training for the International Society of Schema Therapy certification, and continuing education programs. It assumes the following:

1. The trainer is knowledgeable about and competent in ST.
2. The trainer can provide good demonstrations of how to use ST skills across a range of therapeutic situations, via role-play, or the trainer has access to examples of ST being demonstrated through psychotherapy video recordings.
3. The trainer can provide feedback to students regarding how to craft or improve their application of ST skills.
4. Trainees will have accompanying reading, such as books and articles, that explain the theory, research, and rationale of ST and each particular skill.

The exercises covered in this book were piloted at 19 training sites from across four continents (North America, Europe, Asia, and Oceania). This book is designed for trainers and trainees from different cultural backgrounds worldwide.

This book is also designed for those who are training at all career stages, from beginning trainees, including those who have never worked with real clients, to seasoned therapists. All exercises feature guidance for assessing and adjusting the difficulty to precisely target the needs of each individual learner. The term *trainee* in this book is used broadly, referring to anyone in the field of professional mental health who is endeavoring to acquire ST skills.

## Deliberate Practice in Psychotherapy Training

How does one become an expert in their professional field? What is trainable, and what is simply beyond our reach, due to innate or uncontrollable factors? Questions such as these touch on our fascination with expert performers and their development. A mixture

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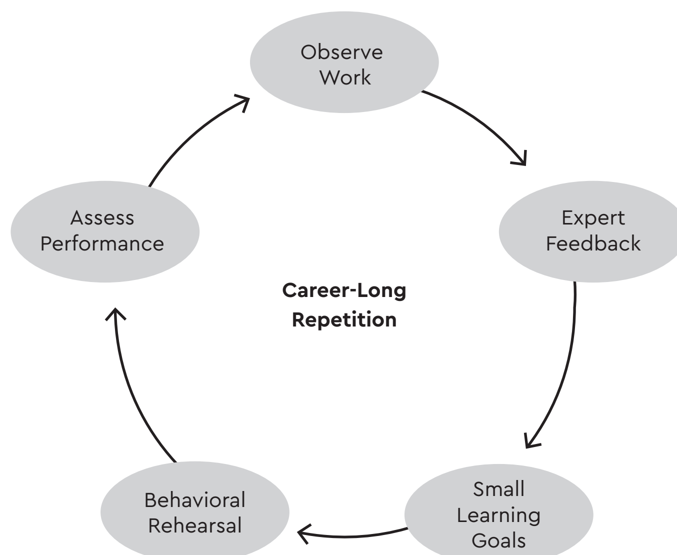
of awe, admiration, and even confusion surround people such as Mozart, Leonardo da Vinci, and more contemporary top performers such as basketball legend Michael Jordan and chess virtuoso Garry Kasparov. What accounts for their consistently superior professional results? Evidence suggests that the amount of time spent on a particular type of training is a key factor in developing expertise in virtually all domains (Ericsson & Pool, 2016). "Deliberate practice" is an evidence-based method that can improve performance in an effective and reliable manner.

The concept of deliberate practice has its origins in a classic study by K. Anders Ericsson and colleagues (1993), who found that the amount of time practicing a skill and the quality of the time spent doing so were key factors predicting mastery and acquisition. They identified five key activities in learning and mastering skills: (a) observing one's own work, (b) getting expert feedback, (c) setting small incremental learning goals just beyond the performer's ability, (d) engaging in repetitive behavioral rehearsal of specific skills, and (e) continuously assessing performance. Ericsson and his colleagues termed this process *deliberate practice*, a cyclical process that is illustrated in Figure 1.1.

Research has shown that lengthy engagement in deliberate practice is associated with expert performance across a variety of professional fields, such as medicine, sports, music, chess, computer programming, and mathematics (Ericsson et al., 2018). People may associate deliberate practice with the widely known "10,000-hour rule" popularized by Malcolm Gladwell in his 2008 book, *Outliers*, although the actual number of hours required for expertise varies by field and by individual (Ericsson & Pool, 2016). This, though, perpetuated two misunderstandings—first, that this is the number of deliberate practice hours that everyone needs to attain expertise, no matter the domain. In fact, there can be considerable variability in how many hours are required. The second misunderstanding is that engagement in 10,000 hours of work performance will lead one to become an expert in that domain. This misunderstanding holds considerable significance for the field of psychotherapy, where hours of work experience with clients

**FIGURE 1.1. Cycle of Deliberate Practice**




*Note*. From *Deliberate Practice in Emotion-Focused Therapy* (p. 7), by R. N. Goldman, A. Vaz, and T. Rousmaniere, 2021, American Psychological Association (https://doi.org/10.1037/0000227-000). Copyright 2021 by the American Psychological Association.

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has traditionally been used as a measure of proficiency (Rousmaniere, 2016). Research suggests that the amount of experience alone does not predict therapist effectiveness (Goldberg, Babins-Wagner, et al., 2016; Goldberg, Rousmaniere, et al., 2016). It may be that the quality of deliberate practice is a key factor.

Psychotherapy scholars, recognizing the value of deliberate practice in other fields, have recently called for deliberate practice to be incorporated into training for mental health professionals (e.g., Bailey & Ogles, 2019; Hill et al., 2020; Rousmaniere et al., 2017; Taylor & Neimeyer, 2017; Tracey et al., 2015). There are, however, good reasons to question analogies made between psychotherapy and other professional fields, like sports or music, because by comparison psychotherapy is so complex and free form. Sports have clearly defined goals, and classical music follows a written score. In contrast, the goals of psychotherapy shift with the unique presentation of each client at each session. Therapists do not have the luxury of following a score.

Instead, good psychotherapy is more like improvisational jazz (Noa Kageyama, cited in Rousmaniere, 2016). In jazz improvisations, a complex mixture of group collaboration, creativity, and interaction are coconstructed among band members. Like psychotherapy, no two jazz improvisations are identical. However, improvisations are not a random collection of notes. They are grounded in a comprehensive theoretical understanding and technical proficiency that is only developed through continuous deliberate practice. For example, prominent jazz instructor Jerry Coker (1990) lists 18 skill areas that students must master, each of which has multiple discrete skills, including tone quality, intervals, chord arpeggios, scales, patterns, and licks. In this sense, more creative and artful improvisations are actually a reflection of a previous commitment to repetitive skill practice and acquisition. As legendary jazz musician Miles Davis put it, "You have to play a long time to be able to play like yourself" (Cook, 2005).

The main idea that we would like to stress here is that we want deliberate practice to help schema therapists become themselves. The idea is to learn the skills so that you have them on hand when you want them. Practice the skills to make them your own. Incorporate those aspects that feel right for you. Ongoing and effortful deliberate practice should not be an impediment to flexibility and creativity. Ideally, it should enhance them. We recognize and celebrate that psychotherapy is an ever-shifting encounter and by no means want it to become or feel formulaic. Strong schema therapists mix an eloquent integration of previously acquired skills with properly attuned flexibility. The core ST responses provided are meant as templates or possibilities, rather than "answers." Please interpret and apply them as you see fit, in a way that makes sense to you. We encourage flexible and improvisational play!

### Simulation-Based Mastery Learning

Deliberate practice uses simulation-based mastery learning (Ericsson, 2004; McGaghie et al., 2014). That is, the stimulus material for training consists of "contrived social situations that mimic problems, events, or conditions that arise in professional encounters" (McGaghie et al., 2014, p. 375). A key component of this approach is that the stimuli being used in training are sufficiently similar to the real-world experiences that they provoke similar reactions. This facilitates *state-dependent learning*, where professionals acquire skills in the same psychological environment where they will ultimately perform them (Fisher & Craik, 1977; Smith, 1979). For example, pilots train with flight simulators that present mechanical failures and dangerous weather conditions, and surgeons practice with surgical simulators that present medical complications. Training in simulations with challenging stimuli increases professionals' capacity to perform effectively

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under stress. For the psychotherapy training exercises in this book, the "simulators" are typical client statements that might actually be presented in the course of therapy sessions and call upon the use of the particular skill.

### Declarative Versus Procedural Knowledge

*Declarative knowledge* is what a person can understand, write, or speak about. It often refers to factual information that can be consciously recalled through memory and often acquired relatively quickly. In contrast, procedural learning is implicit in memory, and "usually requires *repetition of an activity*, and associated learning is demonstrated through *improved task performance*" (Koziol & Budding, 2012, pp. 2694, emphasis added). *Procedural knowledge* is what a person can perform, especially under stress (Squire, 2004). There can be a wide difference between their declarative and procedural knowledge. For example, an "armchair quarterback" is a person who understands and talks about athletics well but would have trouble performing it at a professional level. Likewise, most dance, music, or theater critics have a very high ability to write about their subjects but would be flummoxed if asked to perform them.

**The sweet spot for deliberate practice is the gap between declarative and procedural knowledge.** In other words, effortful practice should target those skills that the trainee could write a good paper about but would have trouble actually performing with a real client. We start with declarative knowledge, learning skills theoretically and observing others perform them. Once learned, with the help of deliberate practice, we work toward the development of procedural learning, with the aim of therapists having "automatic" access to each of the skills that they can pull on when necessary.

Let us turn to the theoretical background on ST to help contextualize the skills of the book and how they fit into the greater training model.

## Overview of Schema Therapy

ST, informed by and compatible with developmental psychology theory and research on attachment (summarized in Cassidy & Shaver, 1999) and interpersonal neurobiology (Siegel, 1999), is unique in its strategic integration of experiential, cognitive, and behavioral pattern-breaking interventions, as opposed to general eclectic approaches. The integrative approach of ST may account for the significant effect sizes found in individual and group treatment outcome studies (e.g., Farrell et al., 2009; Giesen-Bloo et al., 2006). These studies demonstrated symptom reduction, improved global functioning, and meaningful, sustainable, personality changes.

### Core Concepts

ST proposes that difficulties in adult life may be linked with unmet core emotional needs in childhood. These basic needs are identified as follows:

- secure attachment/connection to others (includes affection, empathy, safety, stability, nurturance, and acceptance)
- support for autonomy, competence, and sense of identity
- freedom and assertiveness, to express valid needs, thoughts, opinions, and emotions spontaneity and play
- realistic limits and self-control

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*Early maladaptive schemas* (EMSs)—the personality traits that include unchallenged and rigidly embedded maladaptive "truths" (beliefs about ourselves, the world, and our relationships with other people)—may form in response to these unmet needs, carrying intense emotion, rigid beliefs, and bodily sensations, as well as impulses to react, when triggered by conditions that resemble early life experiences, to shut down the unbearable pain associated with EMS activation.

Psychological disorders can be described and understood in terms of the operation of schemas and modes. The concept of modes offers the client and the clinician user-friendly language for identifying these self-defeating patterns of behavior. Aggression, hostility, manipulation, dominance, approval seeking, stimulation seeking, substance abuse, overcompliance, dependence, excessive self-reliance, compulsivity, inhibition, social isolation, and emotional avoidance, as well as internalized demanding, critical, and punishing modes, can all be understood in mode terms as self-defeating responses to schema activation or as internalized self-critical, self-demanding, or self-punishing messages. Clients suffering from severe personality disorders switch modes more frequently because of higher sensitivity to environmental, interpersonal, and intrapersonal triggers, causing sudden behavioral shifts and overly intense reactions. Modes can also stay rigidly entrenched as default ways of being, as in the case of many avoidant clients.

EMSs are thought to result from the interactions of unmet core childhood needs, innate temperament, and other early environmental experiences—nature and nurture. They become the implicitly driven ways of relating to the world under specific and familiar conditions—that is, a blueprint for life and a sense of how the world works. The 18 EMSs identified by Young, which are presented in Appendix C, are based on hypothesized basic needs of childhood (Young et al., 2003). In ST, the definition of EMS is broader than that of cognitive behavior therapy because it includes memories, bodily sensations, emotions, and cognitions. These schemas are formed in childhood and adolescence and develop through adulthood. EMSs are maintained because they filter new experiences, both internal and external, and distort their meaning to confirm the EMS. EMS responses may have been adaptive earlier in life (e.g., the coping modes are versions of fight, flight, or freeze survival responses), but by adulthood they are maladaptive and interfere with people getting their needs met. EMSs become unhealthy core beliefs and rules that a person wholeheartedly accepts. EMSs, while dormant, are easily accessed when activated by internal (implicit memory and the sensory system) or external cues (e.g., interactions with others, certain sights, sounds, smells).

*Schema modes* were defined by Young et al. (2003) as "the current emotional, cognitive, behavioral, and neurobiological state that a person experiences" (p. 43). They can be viewed as parts of self that are triggered when EMSs are activated. Young et al. described four types of modes: healthy adult modes, demanding/punitive inner critic modes, maladaptive coping modes, and innate child modes. These are described in Appendix C.

### The Goals of Schema Therapy in Mode Terms

This book presents 12 core skills of ST. It is important to consider the relevance of these skills in achieving the treatment goals of ST. The primary goal is to build up and fortify the healthy adult mode to enable a person to have an emotionally healthy and happy life. Strengthening the healthy adult mode means that the individual gains greater access to mindful and empathic awareness, caring and thoughtful decision making, and adaptive skills when dysfunctional modes are triggered. In the early stages of ST,

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these are the goals of the therapist, which are seen as part of limited reparenting. In the autonomy stage, these become the goals of the client's healthy adult mode.

1. Care for the vulnerable child mode. This is a function of the internal "good parent" part of the healthy adult mode.
2. Develop awareness of the maladaptive coping modes to be able to choose more effective responses that meet the present need without negative results.
3. Understand and channel angry or impulsive/undisciplined child mode reactions into assertive and effective ways to get needs met.
4. Reduce the power and control of the demanding/punitive inner critic mode and develop ways to motivate oneself positively, accepting mistakes as part of the learning process and taking responsibility for them. This includes setting reasonable expectancies and standards.
5. Be able to evoke the happy child mode to be able to embrace opportunities for joy and play.
6. Be able to access the competence of the healthy adult mode.

### The Stages of Schema Therapy

The course of ST generally has three stages: bonding and emotional regulation, mode change, and autonomy (Young et al., 2003). The order of these stages will vary, determined by the individual client and therapist. Table 1.2 presents the relationship between the stages of ST, the four main components of ST (described in the next section), and the ST deliberate practice skills from Table 1.1.

### The Four Main Components of Schema Therapy Interventions

#### *Limited Reparenting*

*Limited reparenting* (LRP) is both the therapist's role and a treatment intervention. LRP is thought to be an integral part of the change process in ST. It provides corrective emotional experiences, which are essential to heal EMS and provide a base in the experience of having needs met. This base allows the formation of more positive and adaptive core beliefs. In LRP, the therapist models making active choices of healthy and adaptive behaviors to reduce the use of maladaptive coping mode behavior. LRP provides "good parent" responses and messages to reduce the power of the demanding/punitive inner critic modes. In summary, a schema therapist meets the client's needs like a good parent would, bounded by the ethical limits of therapy. In the LRP role, the schema therapist provides safety, understanding, and comfort for the vulnerable child mode; listens to and acknowledges the needs of the angry child; and confronts and sets healthy limits for the impulsive or undisciplined child mode. Clients in the vulnerable child mode need a "good parent" therapist to use the words and tone of a parent talking to a young child who is lonely, frightened, sad, and so forth. Schema therapists become firm and resolute advocates for the vulnerable child, identifying and confronting maladaptive coping modes or inner critic modes, empathizing with the feelings and needs underneath the mode while challenging whether the action taken is effective. Clients with personality disorders or complex trauma require this active reparenting in the early phase of treatment because they are frequently in child modes and have an underdeveloped healthy adult mode.

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**TABLE 1.2. The 12 Skills in Relation to the Stages of Schema Therapy**

| Schema Therapy Component | Deliberate Practice Skill |
|---|---|
| **Bonding and emotional regulation** | |
| Limited reparenting | Skill 1. Understanding and attunement<br>Skill 3. Schema education: beginning to understand current problems in schema therapy terms<br>Skill 4. Linking unmet needs, schema, and presenting problem |
| **Mode change** | |
| Mode awareness | Skill 5. Education about maladaptive schema modes<br>Skill 6. Recognizing the mode shifts of the maladaptive coping modes<br>Skill 7. Identifying the presence of the demanding/punitive inner critic mode<br>Skill 8. Identifying the presence of the angry and vulnerable child modes |
| Limited reparenting, mode healing | Skill 9. Limited reparenting for the angry and vulnerable child modes<br>Skill 10. Limited reparenting for the demanding/punitive inner critic mode<br>Skill 11. Limited reparenting for the maladaptive coping modes: empathic confrontation |
| **Autonomy** | |
| Mode management | Skill 2. Supporting and strengthening the healthy adult mode<br>Skill 12. Implementing behavioral pattern breaking through homework assignments |

*Note*. The gray rows represent the three stages of schema therapy. Each stage contains one or more of the four components of schema therapy: limited reparenting, mode awareness, mode healing, and mode management.

As the client's healthy modes develop, the therapist shifts, becoming poised in the role of a healthy reparenting agent for an adolescent or a healthy model for the developing adult. Clients will still need connection with the therapist in the later phase of treatment, but they can do most of their own "reparenting" from what they have internalized into their further developed and fortified healthy adult (Younan et al., 2018). Schema therapists are keen to recognize that the strategies, including use of language, level of sophistication, and timing/pacing of strategy application must take into account and be consistent with the client's developmental capacities, comorbidity challenges, and any at-risk issues.

Limited and adaptive reparenting starts with a robust assessment and schema conceptualization that inform treatment goals and strategies. The therapist is poised in an active, supportive, and authentic relationship with the client, one that offers safe connection and a human realness devoid of therapeutic jargon and hierarchical posture. The client is welcome to express vulnerability—emotions and needs. The therapy relationship, albeit limited, fills critical needs–meeting gaps through modeling and mirroring and reimagined ways of experiencing oneself securely attached; ideally, the client feels valued and worthy, often for the first time. Initially, the therapist provides frequent and emphasized reassurance regarding the client's value, security, stability, safety, acceptance, empathy, support, advocacy, and identity. The therapy relationship supports clients learning to meet their needs effectively, improving interpersonal skills and attaining

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autonomy while being able to maintain healthy connection. The ST approach to meeting needs within professional boundaries is quite different than the approach of most other therapy models, which assume more healthy adult mode and skills than clients have and focus too early on clients meeting their own needs when they have never had the experience of them being met. Exercises 1, 2, 3, 4, 9, 10, and 11 in this volume all include aspects of limited reparenting.

### Mode Awareness

*Mode awareness* is usually the first step in the mode change stage of treatment. These interventions are primarily cognitive. Mode awareness work teaches the client to notice when a mode is triggered, identify the underlying schema activated, and the present need (see Appendix C for more details about the relationship between schema mode experiences and underlying, unmet needs). Clients become able to identify their thoughts, feelings, physical sensations, and memories when a mode is present. They learn to connect their reactions in the present to childhood experiences upon which EMS and modes have formed. When clients connect their current situation to childhood memories, they better understand the roots of their schemas and modes (Farrell et al., 2014). Mode awareness is necessary for a client to make a deliberate choice whether to allow a mode to continue or to connect with their healthy adult mode and their skills. Exercises 6, 7, and 8 focus on the mood awareness component of ST.

### Mode Management

*Mode management* skills make use of mode awareness to choose more effective responses. Mode awareness must be present for mode change, but it is not sufficient. The client and therapist evaluate whether the maladaptive mode response will meet their present need or if a different action will be more effective. In mode management work, an alternate, more effective plan to meet the need is developed and implemented. The mode management component of ST includes cognitive, behavioral, and experiential techniques. The therapist identifies and challenges the client's barriers to change, such as actions, cognitive distortions, or beliefs that maintain maladaptive mode behavior. Mode management plans are a powerful method for taking the behavioral-pattern-breaking work of ST out of the therapy room and into the client's daily life (Farrell et al., 2018). There are elements of the mode management component in Exercises 2 and 12. In general, much of this work is in the third stage of ST.

### Mode Healing

*Mode healing* involves experiential mode work, which begins with the corrective emotional experiences of the therapy relationship (e.g., limited reparenting), then goes on to include visual imagery, imagery rescripting, mode dialogues, mode role-plays, and creative work to symbolize positive experiences. These ST interventions are designed to reach deep into the emotional and somatic levels of awareness, targeting early experiences and rescripting experiences that can lead to sustainable levels of change. The skills in Exercises 9, 10, and 11 are part of the mode healing component. Methods for mode healing can be creative and symbolic, such as using art or written material to facilitate the client's recall and the emotional reexperiencing of schema-contradicting events (Farrell et al., 2014).

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### The Schema Therapy Case Conceptualization

ST is guided by a comprehensive case conceptualization, which guides the work and identifies the client's schemas, modes, and unmet needs. The ST Case Conceptualization (downloadable at https://schematherapysociety.org) offers a mutually agreed-upon assessment between therapist and client about how current life challenges and lack of satisfaction may be linked with schemas and modes, providing a therapeutic road map for both formulating and navigating a thoughtful treatment plan. The ST conceptualization also includes the therapist's appraisal of the therapy relationship, including an appreciation for the parallel process of therapist/client moment-to-moment, in-session observations and behavioral responses and the therapist's personal feelings about the client. Each skill in this book targets a schema or mode, often both, and is designed as a step in accomplishing one of the treatment objectives for the given client. For an overview of some major ST concepts, see Appendix C.

### The Evidence Base of Schema Therapy

The evidence base for the effectiveness of ST includes several large randomized controlled trials of individual and group ST for borderline, avoidant, and dependent personality disorders; posttraumatic stress disorder; complex trauma; dissociative identity disorder; eating disorders; and chronic depression (summarized in Farrell & Shaw, 2022). The effectiveness of ST reported in these studies includes decreases in psychiatric symptoms, as well as improved function and quality of life. Clients and therapists were found to prefer ST methods to those of other models in qualitative studies (de Klerk et al., 2017).

## The Role of Deliberate Practice in Schema Therapy Training

ST training already includes a significant amount of dyadic practice. Fifteen of the 40 hours of basic training required for international certification in ST must be dyadic. The importance of clinical skills practice was given empirical support by a study that investigated the role of practice in producing effective schema therapists. Bamelis et al. (2014) found that therapists trained with a practice focus (e.g., role-playing of specific techniques with immediate feedback) were better equipped to apply techniques with real clients than those who only followed lecture-based training.

We believe that the approach of deliberate practice, which includes identifying core microskills, encouraging practitioners to monitor their client outcomes, and a practice system designed to keep therapists in the zone of proximal development, is consistent with the training approach of ST and should improve our current training programs. The goal of deliberate practice to support therapists in making skills their own is consistent with the genuineness and flexibility that effective ST requires.

## A Note About Vocal Tone and Body Posture

ST training emphasizes the need to attend to the nonverbal and paralinguistic cues expressed by both client and therapist. Effective ST involves the therapist's careful, moment-by-moment reading of the client's communication as expressed verbally and nonverbally. The therapist in turn is trained to be aware of their own tone of voice,

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facial expression, and body posture to convey the attitudes of warmth, empathy, genuine curiosity, and openness through their moment-by-moment responding. For each one of the ST skills covered in this book, therapists should be mindful of attending to and practicing their nonverbal interpersonal qualities, such as tone of voice and body posture. It is additionally useful for ST learners to watch recorded examples of ST experts performing therapy so that they can observe these key principles in action.

## Overview of the Book's Structure

This book is organized into three parts. Part I contains this chapter and Chapter 2, which provides basic instructions on how to perform these exercises. We found through testing that providing too many instructions up front overwhelmed trainers and trainees, and they skipped past them as a result. Therefore, we kept these instructions as brief and simple as possible to focus only on the most essential information that trainers and trainees will need to get started with the exercises. Further guidelines for getting the most out of deliberate practice are provided in Chapter 3, and additional instructions for monitoring and adjusting the difficulty of the exercises are provided in Appendix A. **Do not skip the instructions in Chapter 2, and be sure to read the additional guidelines and instructions in Chapter 3 and Appendix A once you are comfortable with the basic instructions.**

Part II contains the 12 skill-focused exercises, which are ordered based on their difficulty: beginner, intermediate, and advanced (see Table 1.1). They each contain a brief overview of the exercise, example client–therapist interactions to help guide trainees, step-by-step instructions for conducting that exercise, and a list of criteria for mastering the relevant skill. The client statements and sample therapist responses are then presented, also organized by difficulty (beginner, intermediate, and advanced). The statements and responses are presented separately so that the trainee playing the therapist has more freedom to improvise responses without being influenced by the sample responses, which should only be turned to if the trainee has difficulty improvising their own responses. The last two exercises in Part II provide opportunities to practice the 12 skills within simulated psychotherapy sessions. Exercise 13 provides a sample psychotherapy session transcript in which the ST skills are used and clearly labeled, thereby demonstrating how they might flow together in an actual therapy session. Trainees are invited to run through the sample transcript with one playing the therapist and the other playing the client to get a feel for how a session might unfold. Exercise 14 provides suggestions for undertaking mock sessions, as well as client profiles ordered by difficulty (beginner, intermediate, and advanced) that trainees can use for improvised role-plays.

Part III contains Chapter 3, which provides additional guidance for trainers and trainees. While Chapter 2 is more procedural, Chapter 3 covers big-picture issues. It highlights six key points for getting the most out of deliberate practice and describes the importance of appropriate responsiveness, attending to trainee well-being and respecting their privacy, and trainer self-evaluation, among other topics.

Four appendixes conclude this book. Appendix A provides instructions for monitoring and adjusting the difficulty of each exercise as needed. It provides a Deliberate Practice Reaction Form for the trainee playing the therapist to complete to indicate whether the exercise is too easy or too difficult. Appendix B includes a Deliberate Practice Diary Form, which provides a format for trainees to explore and record their experiences

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while engaging in deliberate practice. Appendix C contains a review of key concepts in ST that trainees can study to guide their practice when performing the exercises in this book. Appendix D presents a sample syllabus demonstrating how the 14 deliberate practice exercises and other support material can be integrated into a wider ST training course. Instructors may choose to modify the syllabus or pick elements of it to integrate into their own courses.

Downloadable versions of this book's appendixes, including a color version of the Deliberate Practice Reaction Form, can be found in the "Clinician and Practitioner Resources" tab at https://www.apa.org/pubs/books/deliberate-practice-schema-therapy.