Counselling Psychology Quarterly,
Vol. 17, No. 1, 2004, pp. 1–11

BrunnerRoutledge Taylor & Francis healthsciences

INTERVIEW

Interview with Jeffrey Young: reinventing your life through schema therapy

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In 2003 we saw the first edition of *Schema Therapy: A Practitioner's Guide*, the 'bible' of your unique approach. What led you to develop schema therapy? Which main schools did you integrate with CBT to arrive at schema therapy?[1]

What led me to adapt or expand cognitive therapy was the fact that the patients of Dr Beck's centre were mostly research subjects who had been very carefully screened for major depression. But they weren't in many ways typical of patients you see in normal practice. Cognitive therapy was very successful for 70–80% of patients because they were very appropriate for cognitive therapy, and most of them did not have long-term, lifelong problems—they suffered from acute depression. Then when I went into private practice around 1982 I saw a much broader range of patients and the success rate dropped dramatically to below 50%—the therapy wasn't helpful for a lot of patients. Some did very well as expected, but a few would make no progress or only moderate progress and then slip back. With at least half the people I was treating, I wasn't happy with their progress and nor were they really. I felt I had to do something else in order to deal with those patients who were not really responding very well. So I started by looking at what the patients who were not responding had in common, and it was, once I made the list, very obvious. The people who were not responding well were having chronic psychological problems, lifelong problems, such as that they had always been depressed—not always, *but I mean all their adult lives; or even if they weren't always depressed they were anxious at one point or depressed or*

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Counselling Psychology Quarterly ISSN 0951–5070 print/ISSN 1469–3674 online
http://www.tandf.co.uk/journals
DOI: 10.1080/09515070410001701432

unhappy; but basically it was a life of having a pattern of unhappiness. And it was the ones who were happy most of their lives, but then had a problem that came up, who recovered quite quickly. They suffered from a reactive depression. So, basically that's when I realized cognitive therapy, as it was originally developed, wasn't really adequate for what are now generally called 'personality disorders'. So, I decided that I wanted to expand the therapy somehow.

I asked myself what I needed to add to therapy now to go beyond cognitive therapy? The first thing I found was that intellectually cognitive therapy makes a lot of sense but emotionally, I don't feel many issues are addressed. At the same time, I myself was going to a Gestalt therapist, and finding that Gestalt therapy was allowing me to see a lot of things in myself—lifelong issues. So that was the first real thing I added to the cognitive therapy: Gestalt, because it added a whole emotional dimension that cognitive therapy didn't have. Secondly, starting to read a lot of attachment theory, I began to look at people's intimate relationships and realized that so many of these people had unsatisfying intimate relationships. In order to understand why, I had to go back very early—right back to their childhoods; to their emotional register and early attachments. That's when I got interested in the more recent types of psychodynamic therapy, which did address many of these concepts, which looked at emotional attachments, empathy issues and things having to do with atonement between mother and child and separation issues. I began to see that those issues were, as much as I hadn't liked them back at graduate school—with these particular difficult patients—helpful concepts. Although, I found the way they were written to be very convoluted and not very useful there was no treatment outline, it was just a very good description of the problem. So, that's when I started adding some psychodynamic concepts but not the psychodynamic techniques to cognitive therapy. So, just to summarize the integration: object relations, attachment theory, Gestalt therapy with cognitive behavioural therapy.

Thanks to your model and therapy, people who may otherwise be classified as mentally ill and regarded as untreatable psychotherapeutically might be treated by using schema therapy. So, next time a patient says I can't help it, he may not be making an excuse—it could be that he is driven by an automatic activation of maladaptive schemas. So how do you square this with free will or self control?

Well, I guess that I put free will in the category of what you might call the 'adult range'; things like choosing a religion or choosing where you want to go for a vacation—decisions that are not emotionally driven—anything we talk about that isn't deep rooted that's part of our daily life/ daily decisions I think of as free will. However when we get into things that were formed before the person could even think, before the person even had language, like feelings of being unlovable, of feelings that people are going to leave them any time, we may find that those people cling to people later in life. To say that they have free will—it doesn't make sense really—because they're being driven by an emotional part of the brain that only can remember feelings of being abandoned . . .

Right . . . much like an automatic reaction.

Yes. It's completely automatic, the person has no idea they're doing it. They can't stop it, they don't know why they're doing it . . . it can't be free will because they can't even tell you why they're doing it.

And the same would apply to self control? If it isn't free will in a particular instance that they cling to somebody automatically—it's not that they lack self control . . . they might even be appalled at themselves for this behaviour.

Often they are, they say to you why do I keep choosing people like this? Why do I stay in a horrible relationship? Why does everyone hate me? Why do I drive everyone away? They don't want to do these things, they just can't control themselves. Now, that said, I do feel once they enter therapy and they get help understanding and seeing what they could do with their problems, there is free will in deciding how hard you're going to work to change it. Some people don't use their free will to work on their problems. So there's free will later of 'are you going to face your problems and work hard to change them, or are you going to simply allow the emotional part of your brain to drive all of your decisions'. That's where free will comes in, and that's where I hold people responsible, at the point where you know where your problems are and you know there's someone who can help you, and you don't do it or even try to do it, that's the point at which you've used free will or not . . .

By choosing to apply self control, or by showing a lack of self control. . .

. . . because you haven't controlled yourself enough to stay with the therapy or enough to work on your problems.

That's the CBT approach—nobody promised you it was going to be easy.

Right. And that's no different to someone who grew up poor and they want to rise above it. Life involves fighting things that are difficult. We do have free will about whether we want to fight things. If we fight it and we do everything that we're asked to do and we don't get better that's a different issue - that person has exercised free will and they didn't get better: that's not their fault. But to the extent that someone doesn't really try, or doesn't persist in trying long term and commits to changing behaviours that they can see are not helpful.

You need persistence because if you've had a pattern for two, three, four decades . . .

Right. It's a habit but a habit that's earlier than any other habit. Really deep. Most habits that we think of start as a teenager; smoking and so on. But these start maybe already at a year old so they're very deeply ingrained but it is not just a habit—they're emotionally driven—the emotional part of the brain is pushing the person to behave as they do. There's almost a fuel, it's being fuelled. It's not just a habit, something they're familiar with, something is pushing them to do it.

Now looking at religion for example. For some people 'Catholic guilt' is almost intractable. Have you come across this problem and have you treated it?

Does it have to be Catholic, or are we talking about general religious guilt?

Catholic guilt seems to be the best known one. Catholic doctrine teaches that the only way to forgiveness is to go for confession. Catholicism believes that you can remove guilt by going to confession . . .

I've had people with Catholic guilt but it's never been their primary reason for coming to work with me.

But if you want to talk about religious guilt we can generalize it.

Well, I can think of one patient for example. A very very religious orthodox Jewish young person in his 20s. He was struggling with this issue … in orthodox Judaism you're not allowed to masturbate and he didn't have a girlfriend, and in any case he couldn't have had sex with her out of marriage. So he had enormous frustration with regard to his sexual feelings but also enormous guilt having even the thoughts about doing it. So, what I ended up doing was asking him to check out the evidence—he believed it was impossible—he had actually been abstaining so I said I didn't think this was actually possible. I hypothesized that not all of his friends who were orthodox were living up to such high standards. I said you are being much stricter about it I suspect than other Jewish people are. Why don't you ask your friends whether they masturbate? Sure enough, when he asked his friends they all masturbated. Now, what did they do? There is atonement. He atoned. It's like confession—once a year you can atone for your sins and that's what they would do as a way of dealing with it. He still said 'because they sin, doesn't mean I have to sin'. So then I had him go to talk to his rabbi and ask his rabbi what he should do and the rabbi, they were paying for his therapy … and his rabbi said 'it's a sin but we can't keep ourselves from every sin, so this is one of the sins that people often do and they then atone for it later'. And I really concluded that many religious problems have this commonality—patients suffering from religious guilt tend to be more strict about their religion than other people with the same religion. They are brought up in a similar way but they have found a way to work around it within the religion.

They are less perfectionist?

Exactly. People who are Catholic, they have issues with divorce—that's been the same experience—even when they have therapy it's 'well look yes, it's part of the religion but half the people with the religion do it anyway, but basically do you want to be miserable for the rest of your life or do you want to commit a sin?' The average person who's not that rigid eventually, with a lot of encouragement from the therapist, will go ahead and act against the religion. And experience some degree of guilt, but when they realize other people are doing the same thing, gradually guilt goes away. You can also give them things to read, religious books to read, which have alternative points of view. Not every Catholic is as strict about each law as other people. So you can give them other points of view to take into consideration. So religious guilt has never been an obstacle I've had that I wasn't able to overcome.

So you're introducing shades of grey … and trying to make people realize that they're fallible. That being imperfect is part of the human condition.

Fallible and, also I believe that religions are not written in stone. Most religions are a matter of interpretation, so you might as well follow someone with an interpretation more consistent with your own views. Even saying things like 'what do you think God would have wanted you to do?' Forget what the priest or the Pope tells you. If you can think of the basic nature of God in terms of forgiveness or compassion: Would God really want you to do X? I would pose questions of that sort to my patients. Not drawing on specific laws but drawing on the general philosophy of the religion.

Are these laws then consistent with love, kindness and compassion?

Very often the laws are inconsistent with the basic tenets of the religion, so there are many ways around this. Although I will just add, nevertheless, a lot of Catholics still have the guilt but they've learned to act in healthier ways . . . and the guilt gradually gets less . . .

It's manageable?

Yes. It's manageable, it's in the background, so it's there but even if it's there—it doesn't dominate their life completely.

We might not cure people so that they're 100% functional but we don't know anybody who is 100% functional. But we hope as therapists to enable them to enjoy life more, to be more vibrant.

That's right and to get the unhappy parts in the background and the happy parts more in the foreground—even though they're still going to have those unhappy parts.

Reinventing Your Life is something many of us would love to do *but* a Buddhist client, for example, takes it as given that life is full of negative life patterns. Acceptance of this premise as reality, leads to better coping. So being content and finding enlightenment are the goals for life and not feeling good and feeling happy. Is schema therapy therefore only for those who buy into the Western way of life?

I don't know Buddhism well enough. But they wouldn't say, for example, if you're in a relationship and you're being abused you should stay in it and learn to accept it. So, I think a lot of people are misinterpreting it. So as with Catholicism, if people are taking Buddhism so far and are taking it to a ridiculous conclusion, I wouldn't go along with it.

I'm not sure religion is saying 'don't take any steps to improve your life'—it's just saying there's certain patterns you can't change and those you have to accept. Like in the 12 step programme—come to accept the things you cannot change. I think it's more that idea: things you cannot alter or don't know how to alter you have to come to accept. You could have a child that dies very young tragically and you somehow have to try and deal with it. Or you have a son that dies of cancer. Or have a spouse that dies young and you are left without an income—the horrible things that happen to people that one has to adapt to.

Yes, but this does not mean that now you have to stay without an income for the rest of your life.

On the other hand you can't say 'I'm not going to go on with my life' because of these things. You go on but, as you said, you still try to do what you can to improve it. We're trying to say that the things you can't change you learn to accept. And you don't hold onto anger or wishing it was different to the way it really was. You come to accept things as they are. I don't think it's saying 'don't change things that you could change—maybe I'm wrong: people I know who are Buddhists, they would never say to me well . . . even though this is a problem I won't try to change it because I'm a Buddhist'.

I appreciate that schema therapy is an integrative based approach and the results are proof enough for many patients and therapists. However, is there any evidence that maladaptive schemas actually change after successful therapy?

Well, right now I have to say 'no'. But that gets back to a broader question of research. At present we have a large scale study going on in Holland comparing schema therapy with psychodynamic therapy for borderline personality disorder. And, of course, one of the measures will be schemas and we'll know whether schemas change, know whether symptoms change, even whether the costs to society of providing the therapy outweigh the benefits . . . or benefits outweigh the costs. We don't have the answer yet to the question but we're beginning to get answers now as more research projects are being done. Because schema therapy is designed to treat long term disorders it's extremely hard to get funding for research because in the United States - and many other countries—but particularly the US where a lot of the research is done, it's almost impossible to get funding for personality disorder. So we have a problem in that the nature of what we treat, which requires a longer term therapy, no one wants to pay money on the research studies. That's why I'm having to go to other countries and try to train people and encourage them to do studies and get answers to those questions.

Are you intending to test the five core domains[2] a person needs to develop into an emotionally healthy adult empirically in the future, and if so how?

The trouble with needs is that it's very hard to test what they are. What we can test is whether these particular needs group together into the five domains—which we've already tested and we already knew when we wrote Schema Therapy—so they're theoretical groups of needs. We've grouped together needs that are, on the surface, similar. Such as the need to be connected, need for safety; things that we think happen around the same developmental period and are part of the attachment–

–Are you saying that there are core domains that are universal and not just part of the Western view of the world?

Yes! We think of it as the developmental stages of a child, something more like that. But in order to determine whether they're really core needs we would have to be child psychologists doing that kind of research and it would have to be the observation of children that would test that. But so many of the needs we have in here are cited in many other models of childhood needs; it's not like our list is unique. It's just a good a list of needs as anybody has, because I don't think anyone's established scientific data that certain things are actual needs.

Hence sometimes we have to rely on observation–

–Right, we infer that it's a need. Children suffer when they don't get it—so it must be a need. You're looking at it retrospectively because you can't prove it's a need but that if they don't have it there are consequences, so we can say 'well, it must have been a need'.

Let's go back to some other integrative approaches. Could you summarize some similarities and differences between, for example, Marsha Linehan's dialectical behaviour therapy and Arnold Lazarus' multimodal therapy and schema therapy.

We compare dialectical therapy with schema therapy in the book Schema Therapy. But I would say in terms of dialectical behaviour therapy: first of all the obvious difference is that dialectical therapy has a specific, much narrower group of patients that it's developed for. It's developed

for borderline patients and other people with impulsive kinds of behaviours or self destructive behaviours—it's not designed for the whole range of personality disorders. Schema therapy is attempting to treat a much broader Client group—we're trying to deal with the whole range of lifelong problems. Dialectical behaviour therapy is really trying to deal mostly with borderline personality disorders and other impulse and emotional disregulation disorders. Secondly I think dialectical behavioural therapy as it's typically practised proposes two stages: Stage 1 is more of a skills training and reducing the symptoms of a borderline patient and Stage 2 is working on the schemas or core issues. So, since it isn't clear to me how she does that yet—I don't think she's even spelt out how she does it, I think she's to some degree acknowledging that there's a need for both of our approaches to therapy. And I guess I would say the same thing. It's a question that there may be complementary therapies for borderline patients in that they're similar in that both agree that borderline patients are people who didn't get what they needed when they were young, they're very humane and sympathetic views of borderline patients . . . they both acknowledge the importance of validating needs and feelings, they both try to help with emotional regulation. So, I think the philosophies of the two are very compatible. I think the techniques are different in that DBT, at least initially, is symptom focused—it's focused on stopping negative behaviours, using contingencies and skills training. In schema therapy, whilst we do do that too, it is not a long-term goal, it's an interim step. We do want people to reduce their unhelpful behaviours because we don't want them cutting themselves or killing themselves—so we need to keep them alive—but our long range goal is to change their fundamental personality so they're happier people and that is a very long term project for borderline. So, we're trying to change their core issues, core themes, schemas, not just—or even primarily—focus on their acting-out behaviours. I think that's probably the biggest difference, although as I said I think that DBT is more acknowledging the need to do both. It may be at some point the two will come together and there are already people doing both: there are places where people do DBT training and then schema therapy. They're focusing on different aspects of borderline personality disorder. One focusing more on the symptoms and one focusing more on the underlying schemas or issues. I don't think they're at all incompatible.

Why not integrate some integrative approaches?

Exactly. It's a good example of two therapies that could easily be integrated.

Both of you are coming from the same background—trying to improve what's already there. And how does schema therapy compare with multimodal therapy then?

I think with Lazarus, what's similar is that they're both integrated approaches—integrated may be the wrong word here . . . they're both models that utilize multiple techniques and multiple models and draw from several models and techniques—so that's a similarity. And even if you look at the specific techniques they draw on several similar techniques; Gestalt techniques, cognitive techniques . . . At that most basic level they're similar; plus skills training. However, schema therapy lays out a more systematic series of steps that the therapist follows. We are trying to work with the disorder and are more focused on looking at long-term life patterns—like the partners you choose—for patterns you repeat in your relationships. Multimodal therapy is not specifically for personality disorder. It's working with a much broader range of problems so it's less focused negative life patterns, but rather deals with all different types of problems, and that

makes it both broader in one sense and less specific to personality disorder. Schema therapy uses a very specific plan and sequencing in order to deal with that problem. Furthermore, I think we have an integrated conceptual model. In schema therapy we have one developmental and conceptual model. I don't believe, as far as I can tell, that multimodal therapy has one integrated model.

It has the questionnaire which is very, very comprehensive—covering different aspects of your 'here and now' . . .

In the whole field of psychotherapy integration they distinguish between eclectic therapies which are a collection of different techniques borrowed from a number of therapies and an integrated therapy which is actually trying to get theoretically integrated, not just an eclectic mix. So I think multimodal therapy is technically eclectic—it doesn't have a clear-cut integrated conceptual model, whereas schema therapy clearly has.

That's a very helpful explanation. But that you like Lazarus and find him useful is obvious . . .

Yes, he was the very first person who introduced me to cognitive behavioural therapy at Yale, he was my first faculty member, so I guess I have a debt to him since he got me interested in the field. There are definitely excellent parts in his approach. But personally I need a conceptual model that allows me to see it in a pattern and I have a hard time being as eclectic—trying out different things—it's not my personal style.

It seems to suit some therapists more than others and the Multimodal Life History Inventory is an excellent questionnaire to use as an assessment tool. Now, for the more technically minded amongst our readers would you comment on the particular mechanisms of change in schema therapy?

We have four techniques that we're integrating; cognitive, behavioural, experiential and the therapy relationship and we go into them individually. They're all mechanisms of change. For changing patient's beliefs we use cognitive techniques and experiential techniques in which we're trying to get them to create new experiences through imagery exercises and through dialogues that will lead them to make emotional changes. There's specific behavioural change when we actually practice, rehearse and assign very specific behaviour exercises. The most important in some ways is the therapy relationship and that includes 'limited reparenting', the whole way we teach the schema therapist to interact with the patients is probably a very high proportion of the mechanism of change. So I think that as much as the techniques are very helpful the therapy relationship and how we utilize it is a crucial mechanism of change.

So what you are saying is that the therapy relationship could be defined as the skeleton of schema therapy.

That's exactly right. And some of our patients will get better just from the therapy relationship. The majority of our patients—particularly the borderline patients—if you asked them what was most helpful they'd almost always say it was the therapy relationship and focus on aspects of the relationship, and the techniques we use are secondary. Now, the higher functioning patients may say the techniques rather than the relationship. To the extent that we can believe patients we'd

probably have to say the therapy relationship is number one. Maybe the whole conceptual model as a mechanism of change—because it's a way of helping a patient to see their problem maybe is number two.

That might mean you add more weight to who you choose as a therapist and consider as capable of doing this work, rather like 'vetting' somebody who wants to become a priest or a teacher. CBT is a type of therapy for therapists who like structure and teaching clients skills and techniques. Now you are—with difficult-to-treat clients—veering a little away from this mere psycho-educational approach. You seem to indicate that those particular clients actually do need much more than just skills and techniques.

Well, we say that with all clients. All clients need more than skills and techniques. But some clients will get almost nowhere with skills and techniques, others who can still make headway, but with all of our patients the therapy relationship is an essential or very important part of treatment. There is almost no patient where I would say the therapy relationship is not important or a minor part of the treatment. But it's certainly made us very aware of whom we choose as therapists both for outcome studies or for our own centre. We clearly now choose them on their ability to nurture, to be nurturing, to be empathic, to be overtly caring. It's the number one thing we look at, then at skills after that. But if they don't have those qualities we will not hire them regardless of intelligence or what school they came from.

So how exactly do you select future schema therapists?

Actually two or three therapists meet them individually and each person forms their own impression and basically we'll ask ourselves 'how will this person do at reparenting'? Reparenting is our basic style. If you can't imagine this person doing limited reparenting, and we agree—there's consistency amongst the people evaluating the candidate—we won't hire him/her.

This leads on to the next question: do you provide schema therapy accreditation training at your centres and do people who train have to be cognitive therapists?

We're in the process of planning a year long training programme for 2005 to certify people as qualified schema therapists.

Is this a full time training course?

No, as we also want to try and offer it in other countries, it will be three long weekends a year and weekly or bi-weekly phone supervision and watching video tapes. Think of the language problems!

So for those cognitive therapists unable to attend workshops because of language problems or financial problems—do you think that studying your three sets of audio tapes and the two books: the practitioner's guide and *Reinventing Your Life*—would give a therapist enough confidence and know-how to practice schema therapy?

No. It has proved to be a very hard therapy to learn. When you read it it is relatively easy to understand, but in actually applying it, there are so many obstacles you come up against. You really need an experienced person [supervisor], initially, to help you know what to do, because with personality disorder patients one gets stuck all the time. I would just say that we couldn't, in the book, explain every way someone might get stuck. The supervision for the first year or so is crucial. I mean, I do think people can do schema therapy, but whether they would do it to a level

where we would certify them, I would say not. They could certainly learn how to do the therapy and help people but not do it, what we would call, well enough.

So, they would need to do the workshops plus a year of supervision?

In general because we're a cognitive therapy centre we prefer them to come in knowing cognitive therapy, although if we had someone who was very motivated and was already very good at schema therapy and willing to learn cognitive therapy we'd consider somebody like that too. However almost all the people we've accepted so far were first trained in cognitive therapy. . .

Now judging from the accolades from your major and pioneering contributions to the cognitive therapy field, do you have a next big idea or are you content that schema therapy is the watershed or paradigm shift in cognitive therapy?

I don't know if I could say that schema therapy is the paradigm shift in cognitive therapy but it may be as far as I'm able to go. I think maybe a person has one really, really good idea in therapy and then you reach a certain age where you take what you have and refine it. So I think that schema therapy will continue to evolve, I still see patients and groups of patients and we still have patients we aren't successful with, we keep trying to expand the model, so right now we're interested in prison populations . . . and I have no doubt that from that work there are some new elements of the therapy that aren't in there now. The more groups, the more populations we try to work with, the more the therapy will expand but whether I think there'll be another paradigm shift within the schema model, I'd love it if there was, but I don't see one right now. Someone else—the history of science suggests—someone will or perhaps cognitive therapy or schema therapy will be replaced with some other model, like a brain model . . . maybe both models will be superseded by some other model. But I really don't know all the answers.

So finally what do you consider to be the most important character trait and attitude in a good therapist?

A characteristic? I don't want to be trite—but deep empathy and understanding would have to be one major thing, the ability to intuit, but that's a much broader thing than just the use of empathy—it's an ability to really understand another person . . . to see what they see, to feel what they feel . . . so I think that the act of true empathy, or deep empathy is only one core characteristic. I'd say a second one is . . . the capacity to convey that you care, that you're competent, that you're a credible source for the patient. That you care, that you're warm. That's the reparenting notion and to convey those things. And that you have enough confidence that people will listen to what you say to them. And then I guess you'd say a conceptual ability, an ability to take complex cases and see patterns and fit pieces of the puzzle together almost at random and see patterns in them and fit them together in a coherent way. If they could do the reparenting, deep empathy, could do the conceptualizing, it would come to the skills aspect. I would say, most people can do skills, if they're educated enough and got through graduate school I wouldn't say it's a main characteristic, it's something that you don't need to be brilliant in order to do it. The real talent of being a good therapist is in these other areas. I think it's in the capacity to do these other things where there's the real challenge. I should add also creativity—the ability to come up with new ways to solve things, new ways to solve problems when the ways you already have don't work. Because people who are locked into the model they have, can't see the patient at times, if he doesn't fit the model quite right. They need to adapt it or they need

something, a technique or strategy that doesn't exist yet and create one and that's a really useful characteristic because most people can't do that.

So a good therapist needs creativity and intuition?

Right, that's really very important.

Notes

1. For materials, forms, inventories and slideshows related to schema therapy please contact Jeffrey Young, Ph.D., Director, Schema Therapy Institute, 36 West 44th Street, Suite 100, New York, NY 10036, USA. Web: http://www.schematherapy.com; e-mail: institute@schematherapy.com; phone/fax:1-212-221-1818.
2. 1. Secure attachments to others; 2. Autonomy, competence, sense of identity; 3. Freedom express valid needs and emotions; 4. Spontaneity and play; 5. Realistic limits and self-control.

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