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The use of imagery in group schema therapy

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Abstract

This article describes using imagery approaches during group schema therapy (GST). Imagery approaches are an important tool for identifying and changing maladaptive schema modes and early maladaptive schemas. It summarises the theoretical background of the group imagery method and practical case vignettes. The text describes methods for using imagery in therapeutic groups, building a safe place, imagery rescribing painful experiences, and dialogue between schema modes. It also stresses challenging matters, like problems with imagery, difficulties trusting another person, and resistance to change. Using imagery in GST is a powerful approach to increase patient results during the therapy.

REVIEW ARTICLE

INTRODUCTION

Imagery has an important role in the various fields of psychological knowledge (Davies *et al.* 2011). It serves as an instrument for inner work, from life stories to painful experiences, the unconscious, and dreams (Liu & Noppe-Brandon 2009; McGonigal 2022). This tool facilitates exploration of the individual's inner psyche and uncharted areas (Pelaprat & Cole 2011), working freely with the inner world and repressed images (Davies *et al.* 2011; Prasko *et al.* 2012).

In psychology, imagination is a powerful instrument. Many intentionally use imagery to picture favourite results (e.g., winning a race), elaborate on earlier painful experiences in a safe atmosphere, manage overwhelming emotions, or relax (Holmes 2007; Yin *et al.* 2022). Imagery provides a strong instrument for discovering the facets of the self and encouragement behaviour transformation (Thomas 2016; Prasko *et al.* 2020). In sports, imagining is valuable for training and enhancing performance. In therapy, imagery has served as an instrument for understanding difficulties and shaping personality features (Kremer *et al.* 2019).

Group therapy effectively changes the psychological problems (Yalom & Leszcz 2005). It offers a safe atmosphere where patients can profit from the qualified attention and help of psychotherapists and the perspectives, experiences, and advice of other group members' (Davies *et al.* 2011).

Schema therapy, a quite new integrative psychotherapeutic approach, emphasises the treatment of complex and enduring personality problems, predominantly patients with personality disorders (Young *et al.* 2003; Arntz & van Genderen 2009). This approach improves classic cognitive-behavioural therapy by integrating approaches of attachment theory, developmental psychology, ego-psychology, and Gestalt therapy into an integrated therapeutic model (Hoffart Lunding *et al.* 2016).

Schema therapy is focused on maladaptive inner schemas that influence the patient's life by activating "modes" of cognition, emotion and behaviour. Children modes are more emotional and impulsive; maladaptive coping modes try to "manage" children modes, and parent modes assess the situation either rationally (Healthy Adult), with kindness (Kind Parent/Good Parent/Caring Parent) or maladaptively (Criticising Parent). "The critic" is often a very active and influential mode in people with personality disorders, compared to the "Kind Parent" mode, which is frequently lacking. Patients undergoing schema therapy know these modes and try to realise them in their own experience (Prasko *et al.* 2020). Imagery can help work with these modes in various ways.

Group schema therapy (GST), an evolution of the original individual schema therapy developed by Jeffrey E. Young, forms a comprehensive model that integrates cognitive, experiential, emotion-focused, and behavioural interventions to disrupt patterns (Farrell 2014). GST is transdiagnostic and can be offered in mixed or homogeneous diagnosis groups over varying lengths and settings (Roediger *et al.* 2018). Originally developed for individuals with borderline personality disorder, GST can also be applied to individuals with other personality disorders, anxiety disorders, mood disorders, and substance abuse (Simpson 2010). Participants of GST have the opportunity, at least to a limited extent, to fulfil their basic emotional needs in a corrective manner. Patients can also discover the interconnections between their actual and childhood experiences. Moreover, they can understand how their experiential and behaviour patterns manifest in the current days within the context of a therapeutic group (Farrell *et al.* 2009; Storebø *et al.* 2020).

METHOD

This article was performed following a systematic exploration of literature focusing on schema therapy, emphasising imagery as a therapeutic strategy. A comprehensive literature review of the application of imagery in adult psychotherapy was also undertaken. These academic resources were contextualised with practical insights from the clinical experiences of group schema therapists who employ these methods.

Systematic reference checks were completed using PubMed, Google Scholar, Web of Science, and PsycINFO databases. The examination strategy combined the keywords "schema therapy," "group," "imagery," "therapeutic strategies," and "adults." The examination generated files describing the role of imagery in GST. These manuscripts were scrutinised, and information relevant to using imagery in group therapy was extracted. A total of 67 articles were used in the text.

RESULTS

General Methods of Working with Imagery in Groups

Imagery can be employed in numerous group strategies. Various methods utilising imagery can be applied to assist group members in becoming cognizant of their relationship problems (Williams *et al.* 2021). Additionally, imagery can be used for individual self-reflection within a group (Brown *et al.* 2019). Visualising a safe place that one of the patients describes, others can embark on a metaphorical "journey" to that place. Other group members can utilise this *safe place* for their own emotional experiences, such as "rescripting" painful or traumatic memories from childhood and adulthood, managing obsessions and phobias, or preparing for future events in the imagery (Brown *et al.* 2019).

The subsequent methods and case vignettes display the use of imagery in GST:

Visual Imagery Meditation: Visual imagery meditation is a practice that employs imagining to realise a deep state of relaxation. Patients are directed

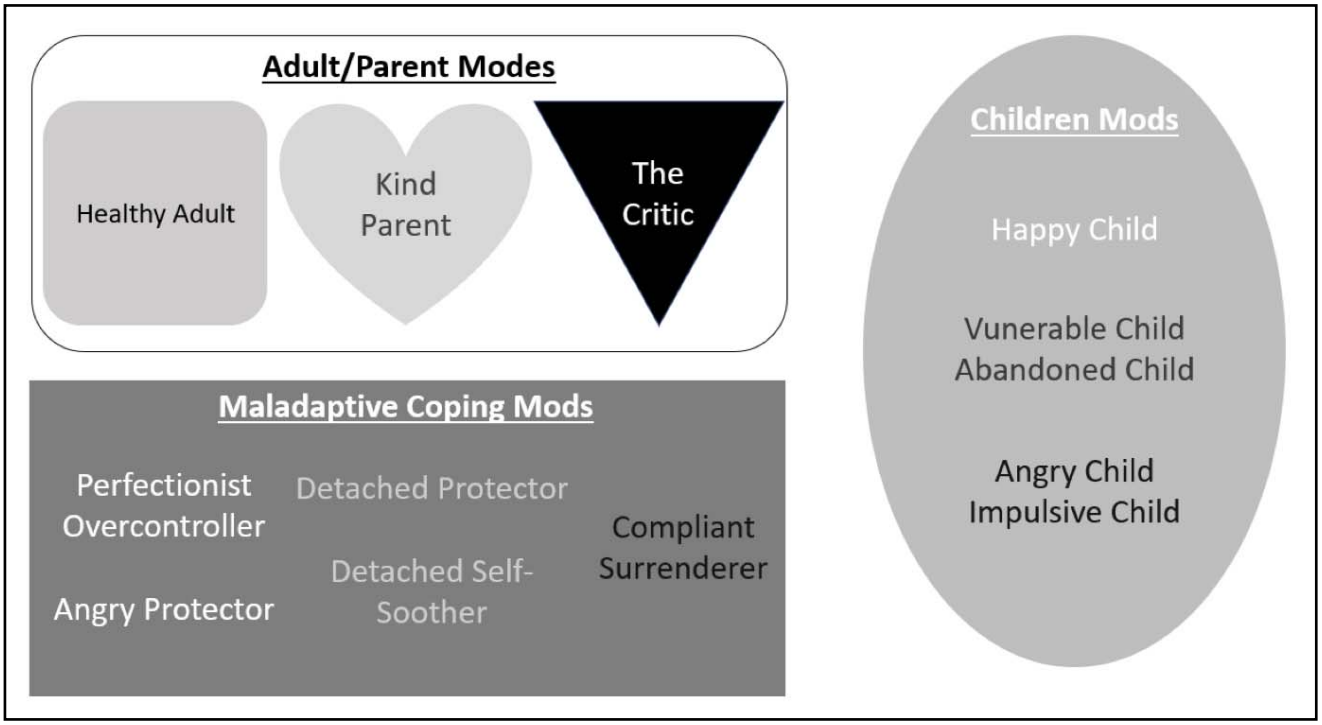

Fig. 1. Basic modes for the psychoeducation in the group

to visualise a circumstance that takes them to harmony and pleasure. This imagery may contain a visualisation of a lovely natural picture, a quiet ocean, or another situation that brings the patient a sense of relaxing and safety. Visual imagery meditation can also be accompanied by other procedures, such as calming belly breathing or body scan mindfulness, to help the person to reach a more profound state of relaxation.

Imaginative Dialogue: Imaginative dialogue is a technique that uses dialogue with an imaginary character to understand and change negative schemas or Inner Critic (i.e. Punitive, Demanding or Guilt-Inducing Parent) or coping modes. The patient is led to a dialogue with a figure representing their negative schema or Inner Critic (Ociskova *et al.* 2022). This figure may represent someone from the patient's past, such as a parent or a teacher, or it may be an abstract representation of a negative feeling or belief. The goal is to understand the negative schema's origin and find ways to change it. After imagery, group members can share their images, and others can express and change them during dialogues and expressive techniques.

Anna imagined her inner child curling up in the room's corner. A huge monster screams at him and threatens to kill him. Around them are thick, opaque metal blinds that prevent anyone from seeing what is happening in the room. After an imagination exercise, the therapist asked the group members to create a sculpture of this scene, where two members formed the Punishing Parent and three members became the wall. Dialogue and group imagery were created with the mods, during which the metal blinds opened up and transformed into a nice light fabric curtain, the Critic was stopped and changed into an old cleaner, and other group members took care of the Inner Child.

Group Imagination: Group Imagination is a technique that uses group dynamics to encourage sharing experiences and mutual support. The group works together to visualise a situation or topic, which can help patients to better understand their own experiences and feelings.

Individual Imagery in Group Schema Therapy

Using imagery, patients can confront individuals who injured or failed to support them during their childhood (Prasko *et al.* 2010; Ociskova *et al.* 2020). Concurrently, the patient addresses the needs of their Vulnerable Child, a crucial aspect of their emotional health (Roediger *et al.* 2018).

When working with a patient in one of the Vulnerable Child modes (e.g. Lonely Child, Dependent Child, Abused Child, Inferior Child mode, etc.), therapists strive to provide them with external support and safety (from themselves, groups, and memories of people who protected them) and to make them aware of the resources coming from their Healthy Adult and Kind Parent modes. This intervention connects the Healthy Adult or Kind Parent and Vulnerable Child modes. This way, when patients realise, they are experiencing the Vulnerable Child mode, they can transition more naturally into the Healthy Adult or Kind Parent mode.

Therapists ask patients to close or open their eyes at various stages of imagery work. Typically, the eyes are closed when there is a need to focus on the image in the

imagery, and the eyes are opened when the attention shifts to the present and the group. Since eye contact is a vital means of emotional connection, when a therapist wants members to focus on returning to the group or connecting with others, they are encouraged to look around and try to notice what they see (Tomasulo 2014). Initially, when working with one member in imagery, the rest of the group usually have their eyes open. Once each group member has gained experience working with imagery, the therapists can ask the whole group to close their eyes and accompany the "protagonist" through their story. In the case of a painful or traumatic event that most group members have not experienced, they may not imagine it with the protagonist, as the therapeutic value would be minimal.

As for individual exercises, for example, patients in the group discuss their needs as children that their loved ones did not meet. This shared experience can facilitate a better understanding of their needs and emotions (Arntz & van Genderen 2009).

Patients can also associate images from their childhood with stressful situations in their present lives. Ideally, this process can aid patients in better understanding their emotions and reactions. Imagination can then be accompanied by rewriting (i.e., "rescripting"). They then reinterpret childhood and adulthood experiences that contradict the message of the maladaptive schema (Ociskova *et al.* 2020).

Patients may also be trained in conversations with important persons from their present lives, either in their imagery or role-play. This exercise can improve patients' capability to manage relations and communicate more successfully (Arntz & van Genderen 2009). Experiential methods at an emotional level aid in overcoming the schema maintenance cycle (Ociskova *et al.* 2020).

The Imagery of The Whole Group

Whole group imagery is a method regularly used in GST. This technique includes the whole group together imagining a situation (Tenore *et al.* 2022). The procedure has some advantages and disadvantages. Primarily, it aids patients in gaining a better understanding of their own experiences and emotions. When patients share their visualisations with other group members, they can acquire new perspectives and insights into their problems and challenges (Finn *et al.* 2023). This experience heightened a sense of belonging and shared understanding.

The procedure of whole-group imagery starts with the group leader suggesting a topic to visualise. This theme could be important to the group or associated with a concrete problem the group addresses (Davies *et al.* 2011). Group members are guided to visualise the topic or situation as vividly as possible. They may be invited to imagine their feelings and what they see, hear, smell, taste, or touch (a sensational focus) and guided to imagine how they would behave in an assumed situation. During this procedure, patients are encouraged to share their imagery. The sharing can be manifest in different forms of expression, such as debate, drawing, and writing (Farrell *et al.* 2009).

Following the imagery process, there is reflection and discussion. Group members can discuss important aspects of the visualisation, the feelings or thoughts it evoked, and the actions they might take in response to their newfound insights (Gilbert & Wilson 2007).

For instance, to enhance safety and work with children, therapists can introduce a therapeutic story to the group (Zehetmair *et al.* 2020). Such a story can inspire patients to empathise with aspects of the story and recognise unfulfilled needs by accessing inner child modes and experiencing the protection of a Kind Parent or Healthy Adult (Zindel 2001; Farrell *et al.* 2009).

That process allows patients to mirror children's vulnerability and dependency on a Good Parent to satisfy their basic emotional needs (Williams *et al.* 2021). Patients are encouraged to reflect on the messages a child might internalise from the story about themselves. Patients are then fortified to consider their Vulnerable child and their needs in the same way and extend to their Vulnerable child the compassion they felt for the child in their imagery.

Four-year-old Alice was startled from her sleep in the middle of the night by strong storms. Her bed shook as they rumbled so terribly. Strange shadows were cast on the room's walls, along with bright flashes of lightning. Frightened, Alice jumped out of bed and rushed to her parents' bedroom. Her screams grew louder with each crash and flash.

Alice's cry startled both her parents from their sleep. She was yelled at to stop sobbing and go back to bed. Alice was afraid, but her father told her it was a storm. And big girls are not scared of storms. Go to bed and be quiet before you wake the whole household." Embarrassed and startled, Alice bit into the covers and tried to stifle her cries and sobs. She covered her ears to block out the rumbling of thunder and closed her eyes to avoid the menacing shadows on the walls. She sat in her bed and stared blankly into the room before her, trying to control her fear.

Using Imagery When Working with Coping Modes in Group Schema Therapy

Imagination allows patients to approach abstract concepts, such as coping strategies, more concretely and emotionally. This method helps make what happened or what they would need or want more tangible, thus strengthening the therapeutic process (Yakın & Arntz 2023). Working with coping methods allows patients in the group to better understand their reactions and behaviour (Farrell *et al.* 2009; Arntz & Jacob 2012). The group framework provides a safe environment for exploring and experimenting with new response mechanisms and communication styles. Patients learn from each other and receive mutual support and feedback (Farrell *et al.* 2005). Below is an example of the visualisation of modes:

- ***Perfectionistic Overcontroller:*** This mode can be visualised as a rigid, unyielding pattern that persistently tries to control everything and everyone and overcome all obstacles. Patients are asked to visualise this mode as a horse that keeps trying despite being tired and stiff. Then, they work on strategies to "calm down" or "direct" the figure so that it does not overexert itself (Young *et al.* 2003).
- ***Detached Protector:*** This mode can be considered a protective shield or wall. It offers protection but prevents anything from being experienced behind it. It prevents the experience of full emotions. Patients can be encouraged to imagine this net gradually decreasing, making it easier to become more open and accessible to their emotions and feelings (Farrell *et al.* 2005).
- ***Compliant Surrender:*** This mode can be visualised as a tired little child giving up. Patients are encouraged to imagine providing protection and support to the young surrendering child, reminding them of their childhood achievements and their right to be unhappy or angry (Young *et al.* 2003).
- ***Detached Self-Soother:*** This mode can be visualised as a pampering and indulgent parent. Patients can be asked to imagine saying no to this parent, asserting something like: "I am an adult, and I want to handle it. I do not want to run away, and I want to manage stress and discomfort better" (Farrell *et al.* 2005)
- ***Angry Protector:*** This mode can be visualised as a fighter or soldier attacking without threat. This fighter can be imagined as someone who still feels that they are on the battlefield even though the attack is over. Patients may be encouraged to visualise this fighter gradually calming their anger, ceasing to overattack, and becoming more controlled and composed, which may suit the overall setting of peace rather than a battle (Young *et al.* 2003).

Child Modes in Imagery

Child "modes" are concepts used in schema therapy to describe various emotive conditions a patient could experience (Salgó *et al.* 2021). These modes consist of "Vulnerable Child", "Abandoned Child", "Angry Child", "Impulsive Child", and "Happy/Satisfied Child". Each mode indicates different sides of a person's character and can be attached in therapy for understanding and healing (Young *et al.* 2003; Renner *et al.* 2013).

Working with Vulnerable Child

Vulnerable child is a mode that includes feelings of fear, loneliness and vulnerability (Prasko *et al.* 2020). In a group setting, working with imagery often commences with each patient, creating a safe place in their imagination (Roelofs *et al.* 2016). Once a sense of safety is induced, signalled by patients raising their hands, they imagine their Vulnerable Child in any situation they can conceive. They explore how they feel about it and what they experience. After 3 - 5 min, they should return to their group place, become aware of the seat they are sitting on, open their eyes, and look around. Subsequently, the patients share their experiences. One group member usually reacts more emotionally than the others, and the therapists offer this person the task of rescripting their experience in the imagination.

The therapist then asks this patient to revisit their idea of the Vulnerable Child and determine what this child needs. The therapist and the group creatively strive to fulfil this person's needs by talking to the selected patient. After rescripting the experience, the patient discusses the feelings they experienced during the imagery. The imagery work is then continued with the other members, each for no more than 10 min, and the group comments on each one. The entire group is encouraged to participate in each piece because the goal is for the group to function as a whole, not for the group members to observe the therapists doing individual work with individuals in the group.

In subsequent sessions, the therapists usually work on other situations related to the Vulnerable Child modes. However, the therapists divide the group into smaller groups, preferably into trios. In each trio, one patient acts as a co-therapist, the second offers recollection, and the third assists. All patients take turns in all roles. Then, all the subgroups report on their progress and what everyone experienced. The therapist sits with one subgroup and pays attention to each member. However, the therapist gently avoids working directly with the subgroups, only stepping in shortly when needed. This approach strengthens autonomy among patients and encourages individual independence.

After finding the perception of a safe place, Monika discovered that she had felt like a Vulnerable Child during the last week because of the anniversary of her boyfriend's death. This anniversary had led her to contemplate her suicide. The therapist encouraged her to retreat into herself, close her eyes, and re-enter the past events when she felt akin to the Vulnerable Child. When Monika confirmed that she had a memory, the therapist inquired about her age in this memory, her actions, her feelings, and her needs. Monika responded that she was nine years old, alone on the playground, feeling abandoned and weak, and in need of support and security.

The therapist questioned if she could sit alongside her and hold her hand. Monika agreed. She said that she felt better now because the therapist, a strong person, was sitting next to her. This calmed her as she saw she was not alone and had an adult's care. She still needed to hear some words of praise. The therapist told her she was intelligent and capable of playing with her friends who came to the playground.

She then encouraged the group to acknowledge Monika as a friend because she needed it. The therapist suggested that the group members return to their Vulnerable Child's feelings because they best understand what other Vulnerable Children need. Individual group members began speaking and complimenting Monika, most expressing happiness that she was kind and enjoyed playing with her.

Next, the therapist suggested whether they would like to join Monika's circle of little friends. They were encouraged to close their eyes and experience what it is like to be connected by hands in a circle. He then asked the group to open their eyes and look around the group. He questioned Monika about how she felt in her imagery and now in the group. Then, the therapist asked the other group members about how they felt and if there was any variance between the feelings of the Vulnerable Child and those they experienced in the initial imagery.
Monika expressed that she felt warmth, protection, and safety, as if she were in the kind of nurturing family she had always wished she had. Others spoke similarly. The therapist asked them to hold onto these feelings for a moment with their eyes closed and realise the strength of the group and each other, including the support they provide each other in the group. Then, they should recognise the strength of their Healthy Adult and Kind Parent that they feel within themselves when they assist someone in the group.

Working with Abandoned Child

This subtype of the Vulnerable Child mode encapsulates feelings of abandonment and loneliness that can surface due to the inadequate fulfilment of basic emotional needs during childhood (Young *et al.* 2003; Puri *et al.* 2021). Thus, the approach to working with this mode in group therapy parallels that of other Vulnerable Child modes.

Patients are encouraged to visualise their Abandoned Child and immerse themselves in their experience. These feelings are then shared in the group, and options are discussed to alleviate these feelings and help meet the " child " needs (Arntz & Jacob 2013). These ideas help a deeper understanding of the experience of the Abandoned Child (Prasko *et al.* 2023).

Zuzana, a patient in GST, relived the feelings of an Abandoned child through her visualisation. These emotional states of anxiety and fear were triggered by the memory of her childhood and of her mother. Mother often left her alone at the flat in the evening and did not return until late at night, even when Zuzana was still a little girl. In these situations, little Zuzana experienced great fear because she was afraid for her mother and herself. She learned to hide it but often found herself crying and feeling abandoned.
In the context of group therapy, Zuzana was directed by the therapist to return to memories of such a situation and to become aware of emotional states. The therapist allowed her to imagine herself as a little girl, abandoned in an apartment, fearfully awaiting her mother's return. This imagery was very emotional for Zuzana. The group imagined how they would walk up to little Zuzka for a visit. In this imagery, the whole group imagined playing together, speaking, and hugging little Zuzana. This imagery of contact with the group members helped Zuzana feel less alone and experience support. The group members showed her that she was important to them, not abandoned.

Working with Angry Child

This mode embodies the frustration and anger that surface when basic emotional needs are unsatisfied (Young *et al.* 2003). In GST, this mode is addressed by instructing patients to recollect situations in which they transitioned into the Angry Child mode. Patients are then led to tranquil down by the Healthy Adult or Kind Parent mode. They are then directed on how to express anger or irritation healthily (Arntz & Jacob 2013).

Martina often was in the Angry Child mode, experiencing intense anger stemming from the feelings that her needs were not being met in her relationship with her partner. She was embroiled in arguments with her partner, whom she blamed angrily. In the group therapy setting, Martina was guided to revisit and relive these feelings. Subsequently, in the presence of the group, the therapist facilitated her visualising herself as a little girl who was angry and frustrated. Martina confronted a situation where her mother criticised her for not playing with her younger sister and refused to give her toys. This imagery was strongly emotive. She felt hurt, but at the same time, she was angry at her mother for forcing her to play with her sister, who was still very little and not fun to play with.
The group then imagined how they came to little Martina. The members gradually spoke towards her, held her and articulated empathy. They hugged her and then started playing with dolls. This group meeting with the group helped Martina feel less angry, more balanced, supported and satisfied. The group demonstrated to her through their imagination that she was not alone and important to them. Following this, Martina and the entire group opened their eyes and shared their feelings from the imagination.
This work with the Angry Child proved to be highly beneficial for Martina. She gained a better understanding of her feelings of anger, as well as the unmet needs that were leading to frustration. She also experienced pleasure from being accepted by the group. The group members were moved by her imagination and felt comfortable imagining protecting her and playing dolls with her.

Working with Impulsive Child

This mode represents impulsive and uninhibited actions that can be apparent as a reply to frustration (Salgó *et al.* 2021). In GST, this mode is addressed by guiding patients to recognise the impulsive tendencies in their memories and use groups to help manage those tendencies in imagery or role-playing. Subsequently, the patients explore their imagination to discover ways to control and manage these tendencies using Healthy Adult and Kind Parent modes (Arntz & Jacob 2013). This procedure nurtures self-regulation and impulse control, building healthy interactive replies.

Carol frequently makes thoughtless choices at home concerning her behaviour, which she later regrets. For instance, she would buy needless things, impulsively spend an extensive sum of money, which she would later punish herself for, or impulsively force her boyfriend to do something unplanned and troublesome. In her imagery, Carol returns to her childhood impulsiveness and the criticism she received from her father. Then, she had to remain seated without moving; if not, she was punished.

Afterwards, the group imagines Carol visiting. They engage in playful antics together, racing each other. When tired, they sit on the carpet and enjoy playing with dolls. This interaction within the group helps Carol feel calm and content. She is emotionally moved in her imagination because she enjoys playing with others. This work with the Impulsive Child mode was of significant importance for Carol. It aided her in gaining a better understanding of her feelings and needs and how to manage them. This work empowered Carol, making her feel stronger and more self-confident and enabling her to manage her emotions more effectively. This experience fostered a sense of unity and mutual understanding within the group, enhancing the overall therapeutic process.

Working with Happy/Satisfied Child

This mode embodies joy, contentment, and happiness. This mode is addressed in GST by instructing patients to recognise and appreciate these pleasant feelings (Young *et al.* 2003).

The significance of spontaneity and play in child development is well-documented, as is the importance of inducing and reinforcing the Happy or Satisfied Child mode in adults (Tenore *et al.* 2022). Play and creativity strengthen healthy emotional growth and offer a primary understanding of social exchanges (Smith & Hart 2002).

Nevertheless, in patients with severe problems, such as borderline personality disorder, narcissistic personality disorder, paranoid, schizoid, avoidant personality disorder, or dependent personality disorder, spontaneity and play were not fulfilled in their families (Young *et al.* 2003). Through imaginative play, it is possible to target emotional schema inhibition or emotional avoidance hypercompensation, as well as mistrust/abuse and social isolation/alienation (Arntz & Jacob 2012). In GST, the imagined Happy Child is often used to induce joyful feelings or balance the painful work of healing the Vulnerable Child (Van Vreeswijk *et al.* 2012).

Pavel has had a habit of suppressing emotions from childhood due to his parents' disciplinary responses. His work with the Happy/Satisfied Child mode was principally important.
Pavel revisited an image from his childhood when he felt isolated and fearful. Now, the group imagines visiting him. They engage in playful activities such as fetching and frolicking in the pool. Pavel can laugh heartily and express joy freely. This interaction in the group helps him experience joy and satisfaction. He is emotionally displaced in his imagery because he feels happy playing with others. This work with the Happy/Satisfied Child mode was immensely important for Pavel. It aided him in gaining a better understanding of his feelings and needs and how to manage them. This work empowered Pavel, making him feel stronger and more self-confident and enabling him to manage his emotions more effectively.

Happy Child Imagination Exercise – Sweet Shop

The therapist guides a group of patients through a live visualisation of a visit to a pastry shop. They tell patients to imagine the tempting colours of treats and sweets, the enticing smell of chocolate and candies, the texture of different candies, and the anticipation of tasting their favourite treats. This pleasant sensory experience evokes pleasant emotions and memories and promotes joy and satisfaction. This method allows for exploring nice feelings, helps build a more positive outlook, and enhances the therapy experience. It is a creative and enjoyable method.

Sit quietly and close your eyes. Inhale and exhale. Imagine that with each inhale, peace and tranquillity enter you, and with each exhalation, peace and tranquillity pass through your entire body, down to the tips of your toes. Inhale and exhale, calm and peace.
Now imagine a quiet street in front of your inner vision. You walk along it, see the sidewalk, cars on the road, shop windows...
In front of you, you see an old-fashioned sweet shop. It has large windows - storefronts. In these displays, you can see desserts, sweets you like, cakes. You stop in front of the door to the candy shop. You enter the confectionery. Pleasant aromas are all around you. They are the aromas of vanilla, candied fruit, chocolate, whipped cream and all sorts of goodies. In the pastry shop, the sounds of the pastry shop are heard pleasantly. You can hear the clinking of cups and saucers and the gentle hum of the coffee machine. From a distance, you can hear the chatter of other customers sitting at their tables, chatting and snacking.
You approach the counter. You see cakes, cookies, chocolate and marzipan figurines before you. An Italian coffee machine sits on the shelf. Choose something you fancy. You carry your treat and join the rest of your group seated at the table. You sit down and give yourself your treat. What does it taste like? How do you feel when you and your group enjoy it in a pastry shop? How does it feel to sit with others and share this atmosphere? What feelings and emotions do these circumstances evoke in you?
Now, we will slowly return to the room where we are sitting. Slowly open your eyes, yawn, and stretch. How do you feel now? Can you describe your experience?

Happy Child Imagination Exercise – Toy Store Visit

A group can greatly benefit from an imagination called "The Toy Store Visit" (Shaw 2010). Visualisation in the "Happy Child" mode can help move a group out of energy, get stuck in negativity, or need reinforcement with a pleasant experience to bring joy and energy to group members.

Imagine yourself and the other group members as small children, and you are waiting for a surprising trip by bus. The bus passes through the city, and you look at the sun-drenched streets and the trees and sing together in anticipation of reaching your destination.
You arrive in front of a vast toy store that houses an endless variety of toys. You will have ample time to explore the entire establishment. Adding to the excitement, the group facilitator won the lottery, and the participants were free to choose any toy they desired from the shop.
Then, you can walk the aisles and interact with and react to your surroundings. Observe your peers, noting their actions and

behaviours within the toy store. Once you pick your toy, you can leave and wait for the others.

Once the imagery exercise concludes, the patients are asked to open their eyes and describe their experiences and the toys they selected. As a facilitator, whether observing or narrating the story, it is delightful to witness the patients' faces light up as they immerse themselves in the imagery, some bursting into laughter, others wearing concentrated expressions as they search for the "perfect toy".

This exercise requires a therapist's tone of voice that exudes joyful curiosity and enthusiasm. That can be challenging for therapists who are tired or experiencing distance or stress. They need to awaken in themselves the feelings of a joyful child. However, a joyful therapist who allows the group to tune into Happy/Satisfied Child modes can help the group experience the joy of exercise.

Standing Against the Critic in Group Imagery

For the "Critical Mod", inner speech is typically full of criticism, self-blame or worries. The person extensively criticises their behaviour, thoughts, motivations and feelings. That can be an obstacle in the therapy process because it reinforces a negative self-view and prevents the development of more adaptive coping.

The Critical mode can manifest itself in different forms:

- ***Criticising (Pure) Critic:*** Critic displays persistent disappointment with the patient's performance. She/she is always looking for what did not go well, did not go perfectly, well enough, or was not pretty or useful enough. Nothing looks good enough. That results in feelings of worthlessness and low self-esteem.
- ***Over-Demanding Critic:*** This form of the Critic pushes one to constantly perform and excel. It operates under a rigid belief system that equates self-worth with achievement. They fail if a person does not meet these excessively high or lofty demands. They are worthless, and they are incapable. That leads to chronic tension, burnout and a pervasive sense of failure.
- ***Self-Blaming Critic:*** This form of criticism leads to the patient blaming themself for their past or present mistakes and failures. They attribute every negative event to their failure, thus promoting shame and guilt. That leads to a negative self-image and an inclination to self-punishing.
- ***Scary Critic:*** This Critic generates fear by emphasising future disasters and the negative consequences of the patient's behaviour. It keeps the patient in constant worry, anxiety and fear. It prevents spontaneity and the ability to take risks and discover new possibilities. It often leads to avoidant behaviour and limits personal growth.

Understanding these different forms of critical mode allows the therapist to tailor interventions to the specific needs of individual patients in the group.

Working with the Critic in the imagination helps patients better understand overwhelming internal conflicts and find ways to resolve them (Koppers *et al.* 2020). Working with the Critic through various exercises helps to better understand it and discover strategies to counter it (Renner *et al.* 2013).

Fighting with a critic requires sensitivity and a deep understanding of the patient's unique experiences and schemas. Also, I need the skill to empower the patient and the group to stand up to the Critic. By "opposing" the Critic through imagery, patients break free from the grip of their inner Critic and clear the way for healthy self-evaluation.

The following are additional exercises that involve working with the Critic:

- ***Dialogue With the Critic:*** The patient imagines that he is sitting across from his Critic and talking to him. He asks Kritika why he is criticising him and his reason for it. Is he doing it because he is worried about the patient? The patient then tells the Critic what the criticism does to him and how it affects him at work, in relationships, and in his free time. Then, the patient tells the Critic how he would like the Critic to behave so that it helps the patient and does not harm him. This exercise promotes self-awareness and assertiveness.
- ***Introducing the Critic to the Group:*** Each member presents their Critic to the rest of the group in this exercise. This lets patients realise they are not alone in their struggles with the Critic and fosters a supportive environment where members can help each other.
- ***Imagery of a Situation Without the Critic:*** This exercise aims to imagine life without the Critic. To realise how life would change. What would this mean for work, relationships, free time? What would he do to make it fun and bring him joy? In addition, it can also help to understand the role that the inner Critic serves the person. On some occasions, the intentions of a critic might be good (e.g., a Demanding critic may want the patient to succeed in life or be noticed by others). Still, the price is too high (e.g., lower self-esteem due to failure, burnout, insufficient resources to fulfil other important emotional and physical needs, etc.). That may create an opportunity to explore how, with the same intentions, a Healthy/Kind Adult mode can keep the same intention but at the same time respond more compassionately and wisely.

Healthy Adult and Kind Parent Modes in Group Imagery

Healthy Adult Mode is a state of mind in which we can solve problems sensibly and behave rationally and effectively. Our Healthy Adult leads us to responsible behaviour, assertive communication, and searching for meaning and priorities.

Working with the Healthy Adult mode in the group from education, through group discussion with a description of typical characteristics, and awareness

of specific situations when group members acted under the guidance of their Healthy Adult in the past and recently, to imagining these situations in the future. Working on this mode in the whole group, including the mutual sharing of own ideas in a group environment, strengthens the awareness of the importance of this mode in life (van Vreeswijk *et al.* 2014).

The therapist can ask the group members to create an idea of how their Healthy Adult would handle a particular problem, how they would handle criticism from an important person, etc. This discussion promotes understanding and cooperation in the group. After the group creates a specific scenario for solving the situation, the therapist guides them to imagine it in their imagination.

The therapist asks the group members to close their eyes. He then asks them to embark on a journey of self-discovery. Patients are asked to imagine their Healthy Adult mode, how they look in it, their tone of voice, how they move, what they do in it, and how they feel. Then, they create their image of the Kind Parent, representing their affection, understanding, and support. After the imagination, the therapist asks the group members to draw these modes and describe around them what they do in them, how they feel in them, and what effect they have on other people. This creation can be a powerful experience, helping them connect more deeply with these parts of themselves.

After creating these characters, group members are asked to describe their characteristics. What does their healthy adult look like? What features does it have? How does he look, how does he talk, how does he act? What does it show on the outside? How does he respond to criticism and problems? The task is to describe the Healthy Adult and Kind Parent to the group members and clarify how they can be a source of strength, understanding and support. Once the group members have formed ideas about these modes, they are to close their eyes and imagine a situation where these modes will take effect. They visualise a scenario that typically triggers their inner Critic and then imagine how their Healthy Adult and Kind Parent would enter the scene and take control of the situation.

With problem-solving abilities, the Healthy Adult might offer rational and effective solutions. At the same time, the Kind Parent provides the emotional support and understanding they need. Through this imaginative exercise, group members can experience firsthand how these modes can help them manage their internal conflicts, stand up to their Critic, and regain control over their lives.

After creating the image of a Healthy Adult and a Kind Parent, it is possible to imagine how these modes enter painful situations from the past and react to them sensibly and kindly, protect one's Wounded Child, and calm the Angry Child. Picture exercises with Healthy Adult and Kind Parent modes help not only to process traumatic childhood experiences but also to accept loss, suffering, sadness and pain in the present. Creating a mental connection in images with other people - living and deceased- is possible during the group process. It is possible to have imaginative dialogues from the point of view of a Healthy Adult, forgiving, asking for forgiveness and expressing gratitude to those we have lost, no matter how difficult or loving the relationship with them was. In imagination, we can encourage acceptance of loss, for example, by imagining a place of peace and safety for those we have lost. Sharing these imaginary scenes with everyone in a group or pairs helps group members process grief, accept loss, foster trust and intimacy with others, and develop mature attitudes toward painful experiences.

Resource-Oriented Interventions

Resource-focused interventions emphasise building and strengthening the patient's internal resources. They are based on the premise that a person has his strengths, which can be well used to overcome obstacles and personal growth (Gilbert & Wilson 2007).

The therapist asks the patients in the group what kind of people they would like to be and encourages them to think about themselves and how they handle things. These are ideal ideas about what a person would like to do, how they would like to speak, and how they would approach problems and obstacles.

Thomas: I think I am incompetent, passive, and inactive.
Therapist: I understand. You have higher demands for yourself. What would you like to be?
Thomas: Well, if I could, I would like to be so active, capable, full of energy and have lots of ideas...
Therapist: That sounds very nice… feeling active, capable, full of energy and having many ideas… What would it be like for you to feel that way?
Thomas: That would be great. I would enjoy it...
Therapist: I see you smiling… tell me about what it would be like to be active, capable, full of energy and ideas…
Thomas: I would stop working as a cleaner and do what I studied for, and I could do it... I would enjoy it... I would get results...
Therapist: You'd go to a job that you would enjoy… imagine that you are already there… what are you doing…. What is it like there for you? Can I ask all group members to use imagery like Thomas's – image the work or study? Which do you prefer?
Thomas: I'm a chemist... we work in a team, and we're looking for a new molecule... I enjoy working with others... It's such a pleasant tension, but will it work out? It's much work and many attempts, but there is a pleasant expectation that it will succeed one day. I enjoy discussing it with my colleagues... I go to lunch with them, and we talk about politics (laughs) and opinions about movies and music... I enjoy it... I have nothing to talk about with the cleaners...
Therapist: What else are you doing?
Thomas: Sometimes we also visit with families and children... it's very nice...
Therapist: I like how nicely you talk about it. What could you lean on to step in this direction?
Thomas: You must have the courage... and go and apply for a position... I've been out of it for a long time because I didn't believe in myself...
Therapist: You believe in that idea… what can you do?

Thomas: I'm going to the laboratory... I want to work there and have little experience, but I would love to do it and learn everything...
Therapist: What does it feel like to say that you will enjoy doing it and learn everything...
Thomas: It's perfect... I want it...
Therapist: Yes. Can we try it now? I'm going to be the lab manager. Are you applying for a job? Do you want to try it?
Thomas: Yeah…
Therapist: Let's do it.
After the imagery is finished, the therapist asks Thomas and the other group members how they experienced the imagery of an ideal job or study.

Dialogue Between Modes in Group Imagery

Dialogue between modes makes it easier for patients to understand and resolve internal conflicts when several modes interact.

Imagery of modes

The therapist helps the group recognise and discuss the ten basic modes (Vulnerable Child, Angry Child, Joyful Child, Critic, Overcompensator, Detached Protector, Self-soother, Complaining Surrender, Healthy Adult, Kind Parent) in various problem situations.

Imagery of modes

The mode dialogue exercise in the group starts with the therapist asking the group members to close their eyes and imagine their modes, which they name and leave a moment for the imagery.

Preparing the masks

Then, the individual members of the group draw or paint one mode on paper plates to prepare masks, and each patient in the group paints a different mode. After cutting out the eyes and mouth on the mask, they then stick the paper plates on a stick and create masks they can hold in front of their faces.

Expression of modes

Then, each patient speaks for the mode he has drawn, describes what happens in him in this mode and when he gets into it, what this mode looks like for him, how he speaks, and how he feels. They then switch modes, and each speaks another mode.

Dialogue of modes

This exercise begins with the therapist instructing the group to close their eyes and visualise the modes involved in a particular problem situation, play a role in these modes, and then build a healthy solution with the Healthy adult and Kind parent modes.

Describing of situation

One of the patients is then the protagonist, who describes the situation that happened to him and the modes that appeared.

Role-playing of modes

The therapist will use the group members to have the protagonists act out the various modes involved in the given situation in previously created paper masks. All members share the experience.

Building a healthy solution

The group discusses how the situation might look better if Healthy adult and Kind Parent modes could enter the mode dialogue.

Imagery of a healthy solution

After creating the scenario, the therapist arranges for the group members to close their eyes and narrate the created constructive scenario. The group members imagined it as if they were watching a movie.

Role-playing of a healthy solution

Ultimately, they play the individual modes of the constructive scenario, with the protagonist playing a healthy adult.

The Importance of Dialogue Between Modes in Group Imagery

This technique helps patients better understand their internal conflicts, particularly those arising from alternating modes. It provides a unique perspective on how different parts of their personalities interact and influence each other.

By visualising/imaging dialogues between modes, patients can observe the dynamics of their internal world more objectively. They can see how one mode might trigger another, how they might conflict or cooperate, and how they might influence their thoughts, feelings, and behaviours.

For instance, a patient might observe how their Vulnerable Child mode, which carries feelings of sadness and fear, might trigger their Detached Protector mode, which attempts to avoid pain by disconnecting them from emotions. From the dialogue between these modes, the patient can gain insights into their patterns of emotional avoidance and learn more adaptive ways of responding to their vulnerability.

Moreover, dialogues between modes can also highlight the roles of the Healthy Adult and Kind Parent modes.

Imagery Rescription in Group Schema Therapy

Imagery rescription allows patients to work with painful, stressful, or traumatic events that cause restlessness and often resurface in memories, accompanied by significant emotional discomfort (Farrell *et al.* 2009). This procedure, known as "painful event rescripting", involves rescripting the narrative of distressing events in a patient's imagery.

Imagery rescription can be applied to an individual's stressful, painful, or traumatic events, effectively rewriting a traumatic event, or it can be used to rescript

a broader view of a life story (Farrell *et al.* 2009; Arntz & Jacob 2012). Therapists will initially lead the imagery rescription process. However, as the group matures, clients can assist each other in small groups or work on independent rescription exercises at home.

Therapists should initially guide the treatment of serious stressful events from childhood and adolescence (Geschwind *et al.* 2024). As therapy progresses, group members are divided into playing three roles: the protagonist (the person whose story is being rescripted), the helper (a supportive group member), and the observer (a group member who provides feedback). This division allows patients to engage with each other's narratives, fostering empathy and mutual understanding (Sosic-Vasic *et al.* 2024).

The rescription of a life story is a continuous process accompanying individual sessions throughout intensive GST during hospitalisation and long-term group schema therapy. During this process, the patient gradually learns to view the events of their life up to the present in new contexts that foster self-acceptance, self-confidence, and self-assurance.

Therapist: Jiří, could you tell us something about your experience as a four-year-old boy in kindergarten?
Jiří: I don't know... But yes, I was a four-year-old boy in kindergarten, and another boy, Rudolf, told me I would have to obey him. Otherwise, there would be war, and it would be my fault. I was afraid that there would be a war and that it would be my fault. I felt there was nothing I could do about it. He is now a prosecutor. I have been obeying his demands all through kindergarten….
Therapist: Thank you, Jiří, for sharing this experience. I wonder what you would need at that moment? And what would you need now that you remember it?
Jiří: Someone who protected me, shouted at him that he mustn't do such things ..... someone who told me that I'm a good boy and I won't do anything bad ...
Therapist: Thank you, Jiří. Now, I want us all to close our eyes and imagine that we are in Jiri's situation. Imagine you are a four-year-old boy in kindergarten, and another boy tells you you must obey him. How do you feel? What do you need?
Jiří: I would need someone to protect me from Rudolf and say that I will not start any war, that I am a good boy and do not want to do anything bad.
Therapist: Jiri, you said you needed someone to protect you and tell you that you are a good boy. Who could it be?
Jiří: Probably my dad, he would shout at him ... but no, he would also yell at me ... I would not like him being present there, more like my grandfather. He would scold Rudolf and then take me to the pastry shop for an ice cream sundae.
Therapist: Thank you, Jiří. Now, I would like us all to close our eyes and imagine that we are in a similar situation from our childhood, as Jiří was. Which situation comes to your mind first? Who was there, where was it, what was going on? Return to the situation in memory for a moment. Now imagine that a protector appears, similar to Jiří's grandfather. Imagine who it is, what they do, and how it protects you. What else do you need to feel good? What does the protector do next? What would it look like? How do you feel then?
(After a while)
Therapist (to all patients): How do you feel now? What would you need from an important person in your life?
Jiří imagined his grandfather stepping into the situation and protecting him from Rudolf. He felt reassured and safe as he imagined his grandfather taking him in his arms and carrying him away.
Another patient, Vlada, imagined a situation from his childhood when his older brother bullied him. He felt reassured and safe as he imagined his grandmother stepping into the problem and protecting him.
Dana imagined her mother criticising her for her performance in school. She felt acknowledged and supported when she imagined her favourite teacher stepping in and protecting her.
Veronika imagined her boss criticising her for her work. She felt recognised and respected when she imagined her colleague stepping into the situation and protecting her.
Zuzka imagined her partner criticising her appearance. She felt beautiful and confident as she imagined her best friend stepping into the situation and protecting her.
Klára imagined her father criticising her for her decision. She felt acknowledged and supported when she imagined her aunt stepping into the situation and protecting her.
Therapist: Thank you all for sharing your needs and feelings. Now, I would like to say, what do you take from this exercise of imagination into your life? How could it help you in your current situation?

It is important to remember that each group member may have a unique experience during this exercise influenced by their personal experiences and emotions (Kroener *et al.* 2024).

Therapist: You said, Mirka, that the way your mother used to lock you at home and leave in the evening was very painful for you...
Mirka: I was very worried... about myself... and my mother... That something will happen to her…. and that I would be alone, without her, lost… I looked out the window at the gate and waited… for hours… then when I saw her outside, opening the gate, I quickly went to bed and pretended to be asleep. She came upstairs and checked me to see if I was sleeping. I learned to take long breaths... but still, sometimes she grabbed me, e.g. because I didn't have a warm duvet... she hit me and yelled at me that I was a brat who couldn't behave properly, that I could be happy, that she takes care of me and didn't put me in a children's home, etc.
Therapist: That must have been painful for you… you were worried about her… you were concerned about being abandoned… and then she hit you and screamed at you…. You didn't deserve that...
Mirka: (crying)... I liked her... and I needed her... I had no one else…
Therapist: Do you think these events may have affected your feelings about people now…? Something like that…. For example, if you are worried about someone, you care about him, and then somehow it happens that he scolds or punishes you in some way....?

Mirka: I don't know. I don't have a similar relationship with anyone as I do with my mother...
Vladan: The way I hear it, you and your Tonda are, at least in my opinion, very similar. You're also still worried about whether he likes you. You try to do everything for him, and then he yells at you when you least expect it because you're trying so hard, and he scolds you for controlling him like a little kid. That is how I understood it when you talked about your relationship. It's a similar pattern - you try, and the other person takes you down.
Mirka: Well... it's similar, you're right... It didn't occur to me at all. Mom is a woman, and he is a man, but then I feel the same. It's like… that I'm not worth it to them… that they don't like me and treat me like an uncle….
Therapist: Good, Mirka. It seems that those past things could connect with current relationships and experiences. Could we try to process one of those events from your childhood with your mother so that it turned out somehow better for you emotionally? Then, it has a chance to influence the current experience less…. Then, process a similar situation with Tonda with what you learn from processing a childhood event…. What do you say to him… can we try?
Petra: That would probably be good... Mom and I also had a hard time. My fingers are crossed for you, Mirka.
Mirka: But I'm afraid I'll get upset and scream because it will hurt so much... I'm not feeling well now that I've started talking about it.
Therapist: Understandably, you're worried about this... it's not entirely easy going back to painful memories... I'll try to help you so that you don't necessarily have to go through the most painful emotions... we'll try to rewrite an incident from your childhood in the way you would most like it to have happened and then add circumstances to your imagination that will increase your sense of acceptance, security and coping... which you would need. It's professionally called the transcription of a painful memory... although it didn't happen that way in childhood, today, you imagine it happened the way you needed it. The next time a painful memory appears, you immediately recall the transcription and associated emotions. Can we try it?
Mirka: Yes... but I have no idea what it could look like...
Therapist: Let's try to find it together... Now try to remember one painful situation with your mother, the one that comes to your mind first and briefly describe to us what happened... and the rest of you in the group, try to close your eyes and accompany Mirka in your imagination… you will be there with her, which can help her….
Mirka: This was repeated many times. Mom left in the evening and told me I had to go to bed and not get out of bed when she got back, to make sure I slept because I had to go to school tomorrow... but that she would come soon...
Therapist: How old are you?
Mírka: I'm a first grader, so I'm about 6.... mom has left, I'm lying down, but I can't stay in bed... I have to go to the window and look at the gate to see if it's possible... it's snowing outside... a street lamp lights the gate... I'm alone in the house... I'm scared... I look out again… no one is going…. I'm afraid mom won't come back…. I don't know what I'm going to do… it takes a long time, I lie down, I can't sleep, so I go to the window and lie down, now I look out of the window for a long time, I'm cold… suddenly mom appears, opens the gate…, I run to bed... I hear her yelling. Mom walks up the stairs, opens the door to the room, looks at me and then puts her hand under the duvet…. She tears the duvet from me and yells at me….
Therapist: Let's stop it... how are you feeling, Mirka...
Mirka: I'm afraid of my mother, but I'm also stiff... as if the feelings are far away... I'm worried that she will hit me, but I don't care either, as if I've disconnected….
Therapist: You described it very nicely, Mirka... I admire your courage and how you went about it...
Vera: I was experiencing it for you… that mom was acting very bad….
Petr: I also got angry with your mother. She can't hurt such a little girl she left alone at home... I'm furious with her. I'd like to slap her a few times... You deserved her to be nice to you. I wished someone was there to send your mother out and hug you….
Therapist: Mirka, was there someone in your life at that time... who, if they were there, could have helped you, protected you, supported you or expressed something nice to you?
Mirka: Nobody. My dad left when I was three. Since then, my mom has had many guys. Two of them lived with us briefly; they were terrible. I remember being afraid of them...
Therapist: And someone in the wider area, from relatives, friends, people you knew and trusted...
Mirka: Our teacher... she was very old but very kind. I liked her very much, and she liked me too... well, she enjoyed all the children... she was very kind... we only had her for the first two years, but I still remember her...
Therapist: Mirka, what should a good teacher do? What would you most need from her?
Mirka: To stop mom. To tell her something, and mom would stop…
Therapist: What should she say that would help you the most?
Mirka: If she said: "Ms Zelenková, Mirka is a very good girl. You must not shout at her or hit her. She is a little child and very good and clever. She doesn't deserve it. Lie down by yourself and leave her alone. I will be here with her now so she can sleep peacefully."
Therapist: You are creating it very nicely, Mírka. Would you like anything else?
Mirka: For the teacher to take me in her arms... stroke my hair... and put me to bed... then hold my hand and tell me a fairy tale... about the princess... she's like me... and it will turn end well (cries).
Therapist: So enjoy it, the narration…. How are you?
Mirka: Pretty good now...
Therapist: So now close your eyes and imagine that nice scenario where you fulfilled your childhood needs for safety, acceptance and appreciation. Try to let it go through your head like a movie. And please tell us the story of what is going on…
Mirka: ... (after a while): I see mom. She's at the gate and closing for her. I run to bed... mom comes in and digs under my covers...
Therapist: When is the teacher coming…
Mirka: Mom starts screaming, then the light comes on, and the teacher is at the door. She is so calm but determined. She says: "Ms Zelenková, leave Mirka and go to sleep." You are drunk. That child needs peace. She is a very nice little girl. And she is very smart in school. I like her very much. I don't want to see you bother her. Now go to your room. I'll wait here with her until she falls asleep...

Therapist: How do you feel…
Mirka: The fear is gone. I am quite well. Mom is leaving. The teacher sits on the bed and hugs me. I feel good with her. She is so big, warm, and firm. She tells me to lie down. Everything is calm, and I can sleep. She says he will be with me until morning before I fall asleep.
Therapist: What is it like?
Mirka: Very nice... I feel beautiful... I'm not afraid of anything... I'm still crying a little... But it's nice (cries). So it could stay forever…. He tells me a fairy tale about Princess Mouse Fur... I felt so good that I fell asleep and had a nice dream about Princess Mouse Fur.
Therapist: So enjoy it for a while…. (after about a minute). When you calm down, Mirka, tell us what you experienced... now I will ask the others what they experienced.
Pavel: I am surprised that I was able to imagine it all. I felt a lot with Mírka - a little girl. I would also help her and hold her hand. I have a little daughter at home, so I imagined holding her hand in the evening and telling her a fairy tale... I have to do it at home right away.
Vladan: I imagined it too, although sometimes I got lost and had problems with my wife. She is also too strict with our children, so I got angry.
Petra: I experienced that it was me. Then I cried, too. It's strange. I have completely different incidents with my mother, but somehow, it's similar. My mother always criticised me….
Therapist: What about you, Mirka? How did you experience it?
Mirka: At first, I felt afraid of my mother, but then, very beautifully, I was completely relieved. It was nice to lie in bed in complete peace. I have to send the teacher a postcard. She is very old now, but she will surely be pleased.
Petra: That's interesting. I felt calm, too. I feel more balanced… at least now, even though it was your event.
Therapist: Maybe the peace and serenity that you, Mirka, experienced affected other people as well... What about the others?
Others nod, feeling calmer and more balanced as if everything can be accepted better.
Therapist: Do you think, Mirka, we could transfer that calmness and serenity to typical situations with a partner? Into something problematic recently?
Mirka: I don't know... maybe...
Therapist: Try to remember a recent situation with Tonda when you felt similar to how you felt with your mother when you were a child...
Mirka: Hmm... I don't know... But maybe... the day before yesterday, I tried to cook salmon, which Tonda likes very much. And he came home from work... he was annoyed and grumpy and came after me, saying that there were a lot of dirty dishes in the kitchen... it was from the cooking... and I didn't have time to wash them... I was looking forward to him enjoying the salmon and being happy, but he hates it because of the dishes in the sink… I was disappointed… and also helpless… I expected him to praise me….
Therapist: If you look at it from the position you now experienced with the teacher, in the transcript from childhood... what could you say to him? How could you react? You can also use some of the way the teacher responded to your angry mother in your imagination…
Mirka: I guess I could tell him that I'm disappointed, that I waited for him and thought he would be happy when I prepared his favourite salmon, and he wasn't happy at all, on the contrary...
Therapist: Excellent, it was like the teacher standing up for you... what else would you need?
Mirka: For him to acknowledge that I wanted something good for him and maybe he was ashamed or apologised for how he reacted...
Therapist: What could you say to him, from your position of calmness and composure... to give him a chance to respond better?
Mirka: I would like him to leave his anger somewhere outside the door. Because I like him, I cooked salmon for him and would like him to have it and see how good it is. I'll wash the dishes later, or maybe tomorrow. Now, I need him to be nice to me and say if he appreciates what I'm doing for him.
Therapist: That's very nice. I like how you did it. You can try to close your eyes and imagine saying it to him like this from your position of peace and calm… can you try?
Mirka: (closes her eyes, speaks calmly) Tonda, I'm sorry you blame me for the dishes. I was looking forward to you. I prepared a salmon for you that you like. Leave your anger at the door now. You are already home, and I love you very much. Please treat me nicely. Eat the salmon, and Tell me how you like your food. Be with me now. It would help me a lot.
Therapist: It sounds very nice and calm. How do you think Tonda would react to that?
Mirka: I wish he would hug me.
Therapist: So tell him…
Mirka: (with closed eyes) he's already hugging me. I can feel his big body... it's nice...
Therapist: So, indulge yourself to feel how nice it is...
In about a minute
Therapist: Let's let Mirka breathe for a while. What was it like for others?
Petra: I would also like to tell Vojta so that he can hug and hold me... I can't help myself. I feel he should figure it out independently, and he won't and won't... so I can try to tell him, as Mírka said.
Pavel: If a woman had said that to me, I would have been ashamed of my anger and cursing, and then I would have hugged her and said sorry.
Vladan: It would do me good, too. Mirka, I want to tell you that you are a fine woman. I admire how you said it. I also need to maintain that calmness and balance in myself.
Therapist: Mirka, you also had a healing effect on the other people in the group. How do you feel now?
Mirka: I feel very well. Now I feel the strength that I will somehow be able to tell Tonda. I'll let you know next time. And thank you to everyone in the group. I still felt your support. Then everything goes better.

New directions in group imagery rescripting

Telehealth is growing rapidly, and therapists are interested in whether techniques used in face-to-face sessions are also effective in digital environments. The preliminary results suggest that remotely delivered ImR (imagery rescripting) in groups focused on childhood

memories leads to cognitive and emotional improvements (Tenore *et al.* 2022). Another study investigates the role of therapists in addressing basic needs and ensuring safety during such interventions (Paulik *et al.* 2021). These researchers also provide a summary that offers practical guidance on these issues.

1. Clinical considerations: Evaluate the context, including living conditions and personal safety. A client might not be alone in their space, live with people who can overhear them or have other circumstances that could decrease a sense of safety. To be aware that clients have a private and secure space for sessions. Address technological challenges, such as strong internet connections, cameras, etc.

2. Therapeutic alliance: Foster a strong therapeutic relationship through consistent and clear communication, ensuring visual and auditory connectivity to capture nuances in facial expressions and body language. To enhance teletherapy sessions, clients and therapists should sit over one meter from the camera and use dual cameras to capture facial expressions and body language. Therapists should verbally validate emotional cues to effectively build rapport.

3. Managing intense emotions: Develop strategies for dealing with intense emotions and potential dissociation during sessions. Use techniques like grounding and use therapeutic items (e.g., blankets, soft toys) within reach.

4. Flexibility and adaptation: Adapt therapeutic protocols flexibly while maintaining the core components of ImRs. Tailor approaches to individual needs and technological capacities.

5. Outcome monitoring: Regularly monitor therapy progress through appropriate scales and feedback to ensure effective therapeutic goals are met.

6. Addressing specific challenges: Be prepared for particular issues like clients feeling less comfortable or secure due to their environment or the perceived impersonality of telehealth settings (Paulik *et al.* 2021)

Benefits and Challenges of Working with Imagery in Group Schema Therapy

Working with imagery in GST offers numerous benefits and presents certain challenges.

Benefits

(a) ***Enhanced Understanding of Internal Processes:*** Imagery allows patients to better understand their internal processes and work towards changing their negative schemas. This introspective approach can lead to significant breakthroughs in therapy.

(b) ***Promotion of Creativity and Self-Expression:*** Using imagination in therapy encourages patients to tap into their creativity and express themselves more freely. This creative outlet can positively impact their psychological health and overall well-being.

(c) ***Increased Motivation:*** Visual meditation and imaginative dialogues can motivate patients to self-improve and strive towards their therapeutic goals. This increased motivation can accelerate progress in therapy.

Challenges

(a) ***Difficulty With Visualisation:*** Some patients may struggle with visualisation techniques and require additional time and support to use them effectively.

(b) ***Resistance to Change:*** Working with imagery can unearth deep-seated emotions and conflicts that lead to resistance. Therapists must manage this resistance and support the patient through their change process.

(c) ***Difficulty With Trust:*** Working in a group requires a certain level of trust between individual members. Some patients may find establishing this trust challenging and need additional time and support to feel safe within groups.

DISCUSSION

Using imagery in GST (group schema therapy) is a powerful tool for accessing and healing early maladaptive schemas and modes. This article has provided a comprehensive overview of the theoretical foundations of this approach, along with practical examples of its application in a group setting. The theoretical underpinnings of this approach are rooted in cognitive behavioural therapy, leveraging the power of visualisation to access deep-seated emotional experiences and memories.

There are numerous benefits to using imagery in GST. It allows patients to access and engage with their emotional experiences on a deeper level than traditional talk therapy often permits. This depth of engagement can lead to profound insights and breakthroughs, as patients can confront and process emotions that may have been suppressed or ignored. Moreover, imagery can help bridge the gap between therapy's cognitive and emotional aspects, facilitating a more holistic healing process.

In addition to its therapeutic benefits, imagery provides a shared experience for the group. This shared experience can foster empathy and understanding among group members as they witness each other's journeys and struggles. This sense of shared experience can strengthen the therapeutic alliance among group members, creating a supportive and nurturing environment.

However, the use of imagery in this context is not without challenges. Facilitating effective imagery exercises requires skill and sensitivity on the therapist's part. It is critical to create a safe and supportive environment where patients feel comfortable exploring and sharing their inner experiences. That requires the therapist to be attuned to the needs and emotional states of the group members and to be able to guide the imagery exercise in a respectful way that validates everyone's experience.

While the examples provided in this article demonstrate the potential of this approach, more research is needed to validate its effectiveness. Future studies could explore the impact of this approach on various outcome measures, such as symptom reduction, improved emotion regulation, and enhanced quality of life. These studies might also investigate the mechanisms through which imagery exercises exert their therapeutic effects, which could lead to the development of more targeted and effective interventions. This would significantly contribute to the field, enhancing our understanding of the therapeutic potential of imagery in GST.

CONCLUSION

This article explored the use of imagination in GST, demonstrating how this approach can benefit patients by outlining the various techniques and exercises employed when working with imagination in a group setting.

Indeed, working with imagination in GST can help participants better understand their internal processes, foster creativity and self-expression, and increase motivation. However, it is important to acknowledge that challenges may arise when working with imagination, such as difficulties with visualisation, resistance to change, or challenges with trust. While significant, these obstacles could be overcome and addressed with the right strategies and interventions.

We hope this article helps inspire further research and development in this area since using imagery in GST represents a promising avenue for enhancing group therapy and improving patient outcomes. However, as with any therapeutic approach, it is crucial to continue evaluating its effectiveness through rigorous research.

REFERENCES

1 Arntz A, Jacob G (2012). Schema therapy in practice: An introductory guide to the schema mode approach. Chichester, UK: Wiley-Blackwell.
2 Arntz A, van Genderen H (2009). Schema Therapy for Borderline Personality Disorder. Chichester, UK: John Wiley & Sons, Ltd.
3 Arntz A (2012). Imagery rescripting as a therapeutic technique: review of clinical trials, basic studies, and research agenda. J Exp Psychopath. **3**: 189–208.
4 Arntz A, Jacob GA, Lee CW, Brand-de Wilde OM, Fassbinder E, Harper RP, Lavender A, Lockwood G, Malogiannis IA, Ruths FA, Schweiger U, Shaw IA, Zarbock G, Farrell JM (2022). Effectiveness of Predominantly Group Schema Therapy and Combined Individual and Group Schema Therapy for Borderline Personality Disorder: A Randomised Clinical Trial. JAMA Psychiatry. **79**(4): 287–299.
5 Barlow DH (2002). Anxiety and its disorders: the nature and treatment of anxiety and panic. 2nd ed. New York: Guilford Press.
6 Bluett EJ, Zoellner LA, Feeny NC (2014). Does change in distress matter? Mechanisms of change in prolonged exposure for PTSD. J Behav Ther Exp Psychiatry. **45**: 97–104.
7 Bouton ME, Mineka S, Barlow DH (2001). A modern learning theory perspective on the etiology of panic disorder. Psychol Rev. **108**: 4–32.
8 Bouton ME (1993). Context, time, and memory retrieval in the interference paradigms of Pavlovian learning. Psychol Bull. **114**: 80–99.
9 Byrne RM (2007). Précis of the rational imagination: how people create alternatives to reality. Behav Brain Sci. **30**(5–6): 439–476.
10 Clark DM (1986ú. A cognitive approach to panic. Behav Res Ther. **24**: 461–470.
11 Craske MG, Kircanski K, Zelikowsky M, Mystkowski J, Chowdhury N, Baker A (2008). Optimising inhibitory learning during exposure therapy. Behav Res Ther. **46**: 5–27.
12 Craske MG, Treanor M, Conway CC, Zbozinek T, Vervliet B (2014). Maximizing exposure therapy: an inhibitory learning approach. Behav Res Ther. **58**: 10–23.
13 Davies J, Atance C, Martin-Ordas G (2011). A framework and open questions on imagination in adults and children. Imagin. Cogn. Pers. **31**: 143–157.
14 Eifert GH, Heffner M (2003). The effects of acceptance versus control contexts on avoidance of panic-related symptoms. J Behav Ther Exp Psychiatry. **34**: 293–312.
15 Farrell JM, Shaw IA, Webber MA (2009). A schema-focused approach to group psychotherapy for outpatients with borderline personality disorder: a randomised controlled trial J Behav Ther Exp Psychiatry. **40**(2): 317–328.
16 Finn E, Torrejon Capurro C, Bennett MG, Wylie R (2023). Applied imagination. Front Psychol. **14**: 1275942.
17 Foa EB, Kozak MJ (1986). Emotional processing of fear: exposure to corrective information. Psychol Bull. **99**: 20–35.
18 Foa EB, McNally RJ (1996). Mechanisms of change in exposure therapy. In: Rapee RM, editor. Curr Control Anxiety Disorder. New York: Guilford Press; 229–343.
19 Frets PG, Kevenaar C, van der Heiden CC (2013). Imagery rescripting as a stand-alone treatment for patients with social phobia: a case series. Journal of Behavior Therapy and Experimental Psychiatry. **45**(1): 143–155.
20 Germain A, Krakow B, Faucher B, Zadra A, Nielsen T, Hollifield M, et al. (2004). Increased mastery elements associated with imagery rehearsal treatment for nightmares in sexual assault survivors with PTSD. Dreaming. **14**: 195–206.
21 Geschwind N, Keasberry E, Voncken M, Lobbestael J, Peters M, Rijkeboer M, van Heugten-van der Kloet D (2024). Imagery rescripting: The value of an added positive emotion component. J Behav Ther Exp Psychiatry. **84**: 101958.
22 Giesen-Bloo J, van Dyck R, Spinhoven P, van Tilburg W, Dirksen C, van Asselt T, Kremers I, Nadort M, Arntz A (2006). Outpatient psychotherapy for borderline personality disorder: randomised trial of schema-focused therapy vs transference-focused psychotherapy. Arch Gen Psychiatry. **63**(6): 649–658.
23 Gilbert DT, Wilson TD (2007). Prospection: experiencing the future. Science. **317**: 1351–1354.
24 Hansen K, Höfling V, Kröner-Borowik T, Stangier U, Steil R (2013). Efficacy of psychological interventions aiming to reduce chronic nightmares: a meta-analysis. Clin Psychol Rev. **33**: 146–55.
25 Hirsch CR., Holmes EA. Mental imagery in anxiety disorders. Psychiatry 2007; **6**(4): 161–165.
26 Hoffart Lunding S, Hoffart A (2016). Perceived Parental Bonding, Early Maladaptive Schemas and Outcome in Schema Therapy of Cluster C Personality Problems. Clin Psychol Psychother. **23**(2): 107–117.
27 Hofmann SG (2008). Cognitive processes during fear acquisition and extinction in animals and humans: implications for exposure therapy of anxiety disorders. Clin Psychol Rev. **28**: 199–210.
28 Jacob GA, Arntz A (2013). Schema therapy for personality disorders – a review. Int J Cogn Ther. **6**(2): 171–185.
29 Karekla M, Forsyth JP, Kelly MM (2004). Emotional avoidance and panicogenic responding to a biological challenge procedure. Behav Ther. **35**: 725–746.
30 Koppers D, Van H, Peen J, Alberts J, Dekker J (2020). The influence of depressive symptoms on the effectiveness of a short-term group form of Schema Cognitive Behavioural Therapy for personality disorders: a naturalistic study. BMC Psychiatry. **20**(1): 271.
31 Koppeschaar A, Bachrach N, Arntz A (2023). Timing of imagery rescripting during schema therapy for borderline personality disorder: the LUCY trial. Front Psychiatry. **14**: 1204439.

32 Krakow B, Hollifield M, Johnston L, Koss M, Schrader R, Warner TD, Tandberg D, Lauriello J, McBride L, Cutchen L, Cheng D, Emmons S, Germain A, Melendrez D, Sandoval D, Prince H (2001). Imagery rehearsal therapy for chronic nightmares in sexual assault survivors with posttraumatic stress disorder: a randomised controlled trial. JAMA. **286**(5): 537–545.
33 Kroener J, Schaitz C, Sosic-Vasic Z (2024). Prospective Mental Images: A Transdiagnostic Approach to Negative Affectivity and Mood Dysregulation among Borderline Personality Disorder and Depression. Behav Sci (Basel). **14**(2): 81.
34 Liu E, Noppe-Brandon S (2009). Imagination first: unlocking the power of possibility. New York: John Wiley & Sons.
35 McGonigal J (2022). Imaginable: how to see the future coming and feel ready for anything-even things that seems impossible today. New York City: Spiegel and Grau.
36 Miller RR, Matzel LD (1988). The comparator hypothesis: a response rule for the expression of associations. In: Bower GH, editor. Psychol Learn Motiv. San Diego, CA: Academic Press; 51–92.
37 Mineka S, Zinbarg R (2006). A contemporary learning theory perspective on the aetiology of anxiety disorders: it's not what you thought it was. Am Psychol. **61**: 10–26.
38 Nilsson JE, Lundh LG, Viborg G (2012). Imagery rescripting of early memories in social anxiety disorder: An experimental study. Behaviour Research and Therapy. **50**(6): 387–392.
39 Ociskova M, Prasko J. Gecaitė-Stonciene J, Abeltina M, Kotian M, Slepecky M, Hodny F, Vanek J, Krone I, Zatkova M, Sollar T, Burkauskas J, Juskiene A (2022). Chairwork in cognitive behavioral therapy and schema therapy: Options in practice. Act Nerv Super Rediviva. **64**(4): 124–141.
40 Ocisková M, Praško JP, Grambal A, Vaněk J, Kotian M, Hodný F, Zaťková M, Šlepecký M, Kotianová A (2020). Přepis bolestných vzpomínek v imaginaci. Psychiatr Praxi. **21**(1): 22–29.
41 Paulik G, Maloney G, Arntz A, Bachrach N, Koppeschaar A, McEvoy P (2021). Delivering Imagery Rescripting via Telehealth: Clinical Concerns, Benefits, and Recommendations. Curr Psychiatry Rep. **23**(5): 24.
42 Pelaprat E, Cole, M (2011). Minding the gap: imagination, creativity and human cognition. Integr. Psychol. Behav. Sci. **45**: 397–418.
43 Prasko J, Diveky T, Grambal A, Kamaradova D, Latalova K, Mainerova B, Vrbova K, Trcova A (2010). Narrative cognitive behavioral therapy for psychosis. Act Nerv Super Rediviva. **52**(1): 135–146.
44 Prasko J, Grambal A, Kamaradova D, Jelenova D (2012). Imagery rescripting of traumatic or distressing stories from childhood. Activitas Nervosa Superior Rediviva. **54**(3): 113–120.
45 Prasko J, Ociskova M, Hodny F, Dicevicius D, Krone I, Juskiene A, Bite I, Kotian M, Albertina M, Slepecky M (2020). Imagery rescripting for the changes of adverse memories and preparation for future. Act Nerv Super Rediviva. **62**(2): 1–9.
46 Prasko J, Ociskova M, Krone I, Gečaitė-Stončienė J, Burkauskas J, Hodny F, Vanek J, Visnovsky J, Genzor S, Juskiene A, Slepecky M, Zatkova M (2023). Dreamwork in schema therapy: Practical steps and case vignettes. Act Nerv Super Rediviva. **65**(3): 98–111.
47 Prinz JN, Lutz W, Bar-Kalifa E, Rafaeli E (2016). Imagery rescripting und psychophysiologische zusammenhänge anhand eines imrs-behandlungskonzepts für prüfungsangst: Überblick und erste Erfahrungen. Psychotherapie Psychosomatik Medizinische Psychologie. **66**(12): 481–485.
48 Puri P, Kumar D, Muralidharan K, Kishore MT (2021). Evaluating schema modes and cognitive distortions in borderline personality disorder: A mixed-method approach. J Clin Psychol. **77**(9): 1973–1984.
49 Renner F, van Goor M, Huibers M, Arntz A, Butz B, Bernstein D (2013). Short-term group schema cognitive-behavioural therapy for young adults with personality disorders and personality disorder features associations with changes in symptomatic distress, schemas, schema modes and coping styles. Behav Res Ther. **51**(8): 487–492.
50 Roediger E, Zarbock G, Frank-Noyon E, Hinrichs J, Arntz A (2018). The effectiveness of imagery work in schema therapy with couples: a clinical experiment comparing the effects of imagery rescripting and cognitive interventions in brief schema couples therapy. Sexual and Relationship Therapy. **35**(3): 1–18.
51 Roelofs J, Muris P, van Wesemael D, Broers NJ, Shaw I, Farrell J (2016). Group-Schematherapy for Adolescents: Results from a Naturalistic Multiple Case Study. J Child Fam Stud. **25**: 2246–2257.
52 Rotter JB (1996). Generalised expectancies for internal versus external control of reinforcement. Psychol Monogr. **80**: 1–28.
53 Salgó E, Bajzát B, Unoka Z (2021). Schema modes and their associations with emotion regulation, mindfulness, and self-compassion among patients with personality disorders. Borderline Personal Disord Emot Dysregul. **8**(1): 19.
54 Sempértegui GA, Karreman A, Arntz A, Bekker MH (2013). Schema therapy for borderline personality disorder: a comprehensive review of its empirical foundations, effectiveness and implementation possibilities. Clin Psychol Rev. **33**(3): 426–447.
55 Sosic-Vasic Z, Schaitz C, Mayer B, Maier A, Connemann B, Kroener J (2024). Treating emotion dysregulation in patients with borderline personality disorder using imagery rescripting: A two-session randomised controlled trial. Behaviour Research and Therapy. **173**: 104454.
56 Smith PK, Hart CH (2002). Blackwell handbook of childhood social development. Oxford, UK: Blackwell Publishers Ltd.
57 Storebø OJ, Stoffers-Winterling JM, Völlm BA, Kongerslev MT, Mattivi JT, Jørgensen MS, Faltinsen E, Todorovac A, Sales CP, Callesen HE, Lieb K, Simonsen E (2020). Psychological therapies for people with borderline personality disorder. **5**: CD012955.
58 Tenore K, Mancini A, Luppino OI, Mancini F (2022). Group Imagery rescripting on childhood memories delivered via telehealth: a preliminary study. Front Psychiatry. **13**: 862289.
59 Tomasulo DJ (2014). Action methods in group psychotherapy: Practical aspects. New York: Routledge.
60 van Vreeswijk M, Broersen J, Nadort M (2012). The Wiley-Blackwell Handbook of Schema Therapy: Theory, Research, and Practice. Chichester, UK: John Wiley & Sons, Ltd.
61 Van Vreeswijk M, Broersen J, Nadort M (2012). The Wiley-Blackwell handbook of schema therapy: Theory, research, and practice. Chichester, UK: Wiley-Blackwell.
62 Van Vreeswijk MF, Spinhoven P, Eurelings-Bontekoe EH, Broersen J (2014). Changes in symptom severity, schemas and modes in heterogeneous psychiatric patient groups following short-term schema cognitive-behavioural group therapy: a naturalistic pre-treatment and post-treatment design in an outpatient clinic. Clin Psychol Psychother. **21**(1): 29–38.
63 Veale D, Page N, Woodward E, Salkovskis P (2015). Imagery rescripting for obsessive compulsive disorder: A single case experimental design in 12 cases. Journal of Behavior Therapy and Experimental Psychiatr. **49**(Special Issue): 230–236.
64 Vujanovic AA, Hart AS, Potter CM, Berenz EC, Niles B, Bernstein A (2013). Main and interactive effects of distress tolerance and negative affect intensity in relation to PTSD symptoms among trauma-exposed adults. J Psychopathol Behav Assess. **35**: 235–243.
65 Yakın D, Arntz A (2023). Understanding the reparative effects of schema modes: an in-depth analysis of the healthy adult mode. Front Psychiatry. **14**: 1204177.
66 Yalom ID, Leszcz M (2005). The theory and practice of group psychotherapy. 5th ed. New York, NY: Basic Books.
67 Yin B, Wang YX, Fei CY, Jiang K (2022). Metaverse as a possible tool for reshaping schema modes in treating personality disorders. Front Psychol. **13**: 1010971.
68 Young JE, Klosko JS, Weishaar ME (2003). Schema Therapy: A Practitioner's Guide. New York: Guilford Press.
69 Zehetmair C, Nagy E, Leetz C, Cranz A, Kindermann D, Reddemann L, Nikendei C (2020). Self-practice of stabilising and guided imagery techniques for traumatised refugees via digital audio files: qualitative study. J Med Internet Res. **22**(9): e17906.
70 Zindel B (2001). The metaphor goddess in three-quarter time: A relational use of story and metaphor. Clin Soc Work J. **29**(1): 9–20.