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REVIEW ARTICLE

Narrative processes in schema therapy: Theoretical background, clinical methods, and case illustrations

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Abstract

OBJECTIVE: To develop a mechanism-oriented framework that specifies how narrative processes operate within schema therapy, detailing a core sequence of change (activation of emotionally salient autobiographical memories, shift in narrative position, emergence of corrective internal voices, and reconsolidation of meaning) through which narrative-based interventions support identity-level change in individual and group settings.

METHODS: This paper adopts a theory-building approach combining a narrative review with an interpretive qualitative analysis of clinical case illustrations from schema therapy. Case material is used to model recurring mechanisms of narrative change rather than to evaluate treatment efficacy.

RESULTS: Across imagery rescripting, chairwork, therapeutic letters, the River of Life, and the Inner House method, a consistent pattern of narrative change emerged. Core mechanisms included activation of emotionally salient autobiographical memories, a shift in narrative position from child-in-experience to adult author, emergence of corrective internal voices corresponding to the Healthy Adult and Kind Parent modes, and reconsolidation of meaning. These changes transferred into current identity and interpersonal functioning, with reduced dominance of punitive introjects, increased self-compassion, and greater narrative coherence. In group settings, corrective relational experiences were amplified through shared narrative processing.
DISCUSSION: Narrative processes in schema therapy are discussed in relation to narrative identity research, trauma-related memory fragmentation, and emerging findings on memory reconsolidation, with neurobiological links framed as plausible but still tentative. Potential clinical risks, including emotional overactivation and narrative destabilization, highlight the need for careful pacing and integration with stabilization, cognitive-behavioral strategies, mindfulness, and resource-oriented interventions.
CONCLUSION: Narrative processes constitute a central pathway through which schema therapy facilitates identity-level change beyond symptom reduction. A mechanism-based narrative framework may strengthen clinical formulation and inform future research on how and for whom narrative interventions are most effective.

INTRODUCTION

Schema therapy is an integrative psychotherapeutic approach that combines cognitive-behavioral therapy, attachment theory, psychodynamic concepts, and humanistic principles. Its clinical strength lies in a coherent model linking the developmental origins of psychopathology (early maladaptive schemas), their momentary manifestations (schema modes), and targeted strategies for change, particularly through corrective emotional experiences (Young *et al.* 2003; Arntz & Jacob 2013; Lobbestael *et al.* 2010). In clinical practice, however, patients rarely present with schemas or symptoms alone. Instead, they present with personal stories that organize how they understand their past, experience the present, and anticipate the future (Matthews *et al.* 2025; Milan *et al.* 2025).

This narrative dimension is especially salient in patients with personality disorders and histories of early or chronic trauma (Sajjadi *et al.* 2022). In these populations, personal narratives are often fragmented, rigid, or saturated with shame and self-criticism (Adler *et al.* 2012; Faggioli *et al.* 2024). Research in identity psychology demonstrates that individuals construct meaning and continuity through life stories that integrate experiences across time (McAdams, 2001; Lind *et al.* 2020; Vanderveren *et al.* 2021). When development is shaped by neglect, abuse, or prolonged frustration of basic emotional needs, narrative identity may consolidate around painful and restrictive self-representations (Grambal *et al.* 2017; Bendstrup *et al.* 2021; Kantor *et al.* 2022). Patients repeatedly narrate themselves as defective, unworthy, invisible, or destined for rejection (Soroko 2015).

Trauma research further indicates that chronic and early adverse experiences are frequently encoded in a fragmented manner, accompanied by dissociation and disturbances in autobiographical memory (Conway *et al.* 2004; Lind *et al.* 2019a). Rather than coherent narratives, patients often retain isolated sensory images, bodily reactions, and affective fragments that intrude into present experience (Chu *et al.* 1999; Bogaerts *et al.* 2024; Felletár *et al.* 2025). These disruptions have direct therapeutic implications (Lind *et al.* 2019b). Without restoring narrative continuity, it remains difficult to stabilize self-concept, transform internal dialogue, and strengthen the Healthy Adult mode.

From this perspective, narrative functioning provides a conceptual bridge between schemas, modes, and identity (Bois *et al.* 2023; Hallford *et al.* 2024). Maladaptive schemas and modes can be understood as recurring narrative scenarios populated by specific internal voices and roles that are repeatedly reactivated in current situations (Hoffart Lunding *et al.* 2016). Therapeutic change, therefore, involves more than modifying beliefs or behaviors. It requires a transformation of meaning, enabling patients to relate to their past differently, legitimize their previously unmet needs, and construct a more coherent, compassionate, and realistic story about themselves and others (Prasko *et al.* 2010; van Schie *et al.* 2022).

Schema therapy incorporates several interventions that are explicitly narrative in nature. These include imagery rescripting (ImR) of traumatic memories (Arntz 2012; Kunze *et al.* 2016), chairwork facilitating dialogue between internal narrative positions, therapeutic letters addressing significant others or parental introjects (Prasko *et al.* 2009; Pol *et al.* 2024), and group-based life story visualization methods such as the River of Life (Prasko *et al.* 2024b). Beyond emotional processing, these techniques support the reorganization of autobiographical narrative, thereby reshaping patients' answers to the questions "Who am I?" and "What is my story?", a process that is critical for the durability of therapeutic change.

The aim of the present article is to integrate schema therapy with narrative psychology and to articulate a mechanism-focused framework for understanding narrative processes in clinical practice. Specifically, we describe how a core sequence of narrative change operates across techniques and propose a clinical heuristic that distinguishes a repair trajectory (revising deficit- and trauma-centred narratives) from a complementary resource trajectory (activating and consolidating

adaptive self-stories and positive schema evidence) in both individual and group settings. We first outline the theoretical foundations linking schemas, modes, memory, and narrative identity, and describe typical forms of narrative dysfunction observed in clinical populations. We then present key narrative-oriented techniques used in schema therapy and illustrate their application through detailed case studies from both individual and group settings. Finally, we discuss clinical implications, limitations, and potential risks, as well as possibilities for integration with cognitive-behavioral therapy, mindfulness-based approaches, positive psychology, and emerging neuroscientific findings related to memory consolidation.

Rather than presenting narrative techniques as adjunctive clinical tools, this paper conceptualizes narrative processes as core mechanisms of change in schema therapy. By integrating schema theory with narrative identity research, the article aims to clarify how therapeutic change unfolds at the level of meaning, authorship, and identity, particularly in patients with complex trauma and personality pathology.

METHODOLOGY

Design and Epistemological Approach

This article adopts a narrative review design combined with an interpretative qualitative analysis of clinical case illustrations from individual and group schema therapy. Rather than following a systematic review protocol (e.g., PRISMA), the aim is to provide a theoretically grounded and clinically relevant account of narrative processes in schema therapy.

The epistemological stance is constructivist and clinically interpretive, emphasizing meaning-making processes over causal inference. The paper follows a theory-building orientation, using clinical material to illustrate mechanisms of narrative change rather than to evaluate treatment efficacy.

Literature Selection and Theoretical Sources

Literature was selected purposively based on conceptual relevance and clinical contribution. A targeted search was conducted in major databases (e.g., PubMed, PsycINFO, Scopus) using combinations of the following keywords: schema therapy, schema modes, narrative identity, narrative therapy, imagery rescripting, chairwork, therapeutic letters, emotional memory, memory reconsolidation, and trauma.

The primary time frame for the search covered publications from 2000 to 2024, with earlier seminal works included where conceptually essential. Sources comprised schema therapy texts, narrative psychology research, empirical and clinical studies on experiential techniques, and selected neuroscientific findings relevant to emotional memory and reconsolidation.

The selection prioritized conceptual clarity and empirical credibility over exhaustiveness. Citations are used to anchor theoretical claims and situate the analysis within existing research.

Clinical Material and Case Illustrations

The paper includes illustrative case studies derived from long-term clinical practice with patients with personality disorders and complex trauma-related conditions in specialized schema therapy programs. Case material was retrospectively reconstructed and, where appropriate, combined into composite cases to ensure anonymity; all cases are de-identified and presented in a way that prevents recognition. In line with institutional standards, patients provided informed consent for the use of anonymized or composite clinical material for educational and scientific purposes.

Case illustrations are used to model recurring narrative mechanisms of change rather than represent typical outcomes. Descriptions focus on self-narrative organization, schema modes, applied interventions, and shifts in internal dialogue and identity.

Analytical Strategy

Analysis followed a qualitative, interpretive approach informed by schema therapy and narrative identity models. We repeatedly reviewed case material, first within cases and then across cases, to identify convergent patterns in how schemas and modes were embedded in personal narratives, how internal voices and narrative positions shifted during imagery, chairwork, letters, River of Life and Inner House work, and how these shifts related to changes in internal dialogue and identity. Through iterative comparison, we modelled recurring sequences of narrative change that link activation of autobiographical memories, movement between narrative positions, emergence of corrective internal voices, and subsequent reorganization of autobiographical meaning.

The aim is to generate conceptual insight into narrative change processes, with implications for clinical formulation and future research.

THEORETICAL BASIS

Schema Therapy: Schemas, Modes, and the Meaning of Experience

Schema therapy is grounded in the assumption that chronic frustration of basic emotional needs during childhood leads to the formation of early maladaptive schemas that organize how individuals perceive themselves, others, and the world (Young *et al.* 2003; Dadomo *et al.* 2016). These schemas are not limited to dysfunctional beliefs; they represent complex, multimodal patterns integrating emotions, bodily responses, memories, and habitual coping behaviors (Arntz & Jacob 2013; Militaru *et al.* 2025).

In everyday functioning, schemas are expressed through schema modes—momentary states reflecting the currently dominant way of experiencing and

regulating internal and external demands (Simpson *et al.* 2025). Modes encompass vulnerable and dysregulated child states (e.g., Vulnerable Child, Angry Child), maladaptive coping strategies (e.g., Detached Protector, Overcompensator), and internalized parental introjects (e.g., Punitive or Demanding Parent), as well as adaptive modes such as the Healthy Adult and the Kind Parent - also referred to as the "healthy nurturing parent" function in the schema therapy literature (Lobbestael *et al.* 2010; Rafaeli *et al.* 2016).

From the patient's subjective perspective, however, modes are rarely experienced as theoretical constructs. Instead, they appear as inner voices, recurring relational roles, and familiar experiential scenarios that shape the individual's personal story (Engeland *et al.* 2025). Schemas and modes thus function not only as intrapsychic structures but also as narrative organizers of meaning, determining how experiences are interpreted and integrated into identity (Prasko *et al.* 2024a).

Narrative Psychology and the Construction of Identity

Narrative psychology offers a complementary framework for understanding psychopathology and therapeutic change by conceptualizing identity as a life story constructed over time (McAdams 2001; Schoofs *et al.* 2025). Identity is not a fixed entity but an ongoing narrative process that links past experiences, present self-understanding, and anticipated future trajectories to form a relatively coherent whole (Gu & Gao 2025). The *metamorphic model* of narrative identity (Thomsen *et al.* 2025) offers a theoretical framework for understanding how narrative identity interacts with mental illness and recovery. It describes how a person's life story (narrative identity) undergoes qualitative transformations across the course of mental illness and personal recovery. According to the model, negative co-authoring (invalidating feedback from others) and conflicts with cultural master narratives (societal blueprints for success) shape fragile life stories. These fragile narratives are defined by a lack of internal coherence and low agency, meaning the person feels they have little control over their life. Such influences prevent the development of a stable and meaningful life story (Thomsen *et al.* 2025). From a schema therapy perspective, early maladaptive schemas (EMS) can thus be understood as internalized narrative templates shaped in early relationships. Recovery, in turn, is conceptualized as narrative identity change, corresponding to the strengthening of the Healthy Adult as the active author of a more coherent and agentic life story.

Narrative development proceeds from pre-verbal, emotionally and somatically embedded experiences toward increasingly complex and reflective self-narratives (Dimaggio *et al.* 2007; Ong *et al.* 2025). Early caregiver interactions play a critical role in this process by helping the child regulate affect and transform raw experience into shared meaning. When this process is disrupted by neglect, abuse, or chronic emotional invalidation, narrative organization may remain fragmented, rigid, or impoverished.

Clinical research highlights that psychological health is closely associated with the capacity for internal dialogue, perspective-taking, and flexible narrative positioning—that is, the ability to reflect on one's own experience from multiple viewpoints rather than being confined to a single dominant story (Soroko 2013). Conversely, psychopathology is often characterized by narrative rigidity, limited perspective shifts, and the dominance of problem-saturated self-representations.

Memory, Trauma, and Narrative Fragmentation

Memory processes constitute a central point of convergence between schema therapy and narrative psychology. Empirical studies consistently show that traumatic experiences—particularly when repeated and occurring early in development—are often encoded in a fragmented, non-narrative form (Terr 1991; Chu *et al.* 1999). Rather than being integrated into autobiographical memory, such experiences persist as intrusive images, bodily sensations, affective states, or relational reenactments.

This mode of memory storage is closely linked to dissociation and difficulties in constructing a coherent personal narrative. Clinically, this implies that purely verbal reflection is often insufficient for trauma integration. Experiential techniques, particularly ImR, enable reactivation of emotionally charged memory traces while simultaneously introducing corrective elements such as protection, validation, and fulfillment of unmet needs (Arntz 2012; Prasko *et al.* 2020).

Through this process, fragmented memory elements can be gradually embedded within a broader autobiographical narrative that is more coherent, tolerable, and meaningful. Narrative integration thus represents not merely a cognitive reappraisal but a restructuring of emotional memory and its narrative significance.

Integrating Schema Therapy and Narrative Approaches

Integrating schema therapy with narrative psychology allows maladaptive schemas and modes to be conceptualized as components of a repeatedly enacted personal story (Figure 1). Schema activation is expressed not only through emotional or behavioral shifts but also through the activation of specific narrative scenarios in which particular roles and voices dominate; for example, a Vulnerable Child, a Punitive Critic or a Detached Protector.

Therapeutic work, from this perspective, aims not merely to suppress maladaptive voices but to transform the overarching narrative in which they operate. Change involves creating a more coherent and compassionate story that acknowledges unmet needs, contextualizes past suffering, and creates space for agency and realistic hope.

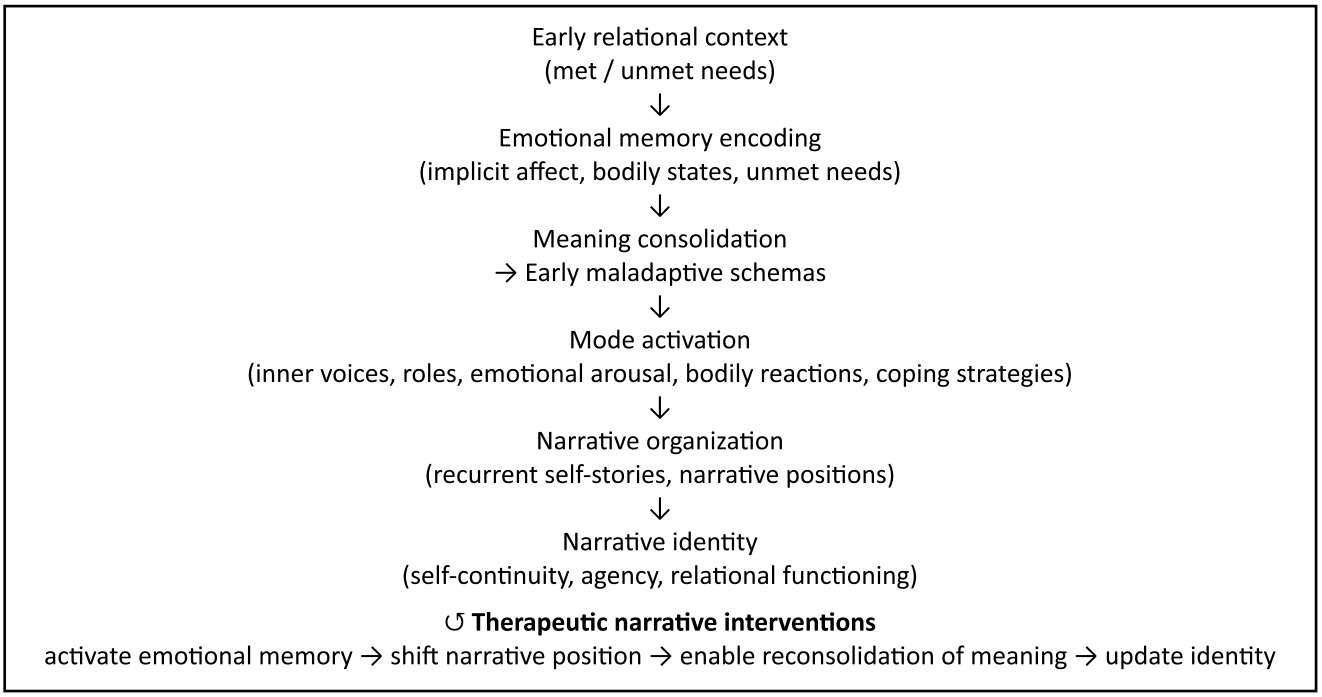

Fig. 1. From early emotional memory to narrative identity: a schema-therapeutic model
This figure illustrates how early relational experiences characterized by the fulfillment or chronic frustration of basic emotional needs are encoded in emotional memory and consolidated into early maladaptive schemas. These schemas are expressed in everyday life through schema modes, experienced as inner voices, relational roles, and coping strategies. Activated modes organize experience into dominant narrative positions, which shape recurrent personal stories about the self, others, and the world. Over time, these narratives contribute to the formation and maintenance of narrative identity and current psychological functioning. Narrative-oriented interventions in schema therapy (e.g., ImR, chairwork, therapeutic letters, the River of Life, and the Inner House) intervene across multiple levels of this process by activating emotional memory, shifting narrative position toward the adult author, enabling reconsolidation of meaning, and supporting identity-level change.

Such narrative reconstruction supports the strengthening of the Healthy Adult and facilitates the development of a more flexible identity that is no longer exclusively defined by trauma, failure, or shame, but also incorporates resources, relationships, and possibilities for change (Soroko 2015; Prasko *et al.* 2024a).

This integrative framework provides the theoretical foundation for narrative-oriented techniques in schema therapy, which are described in the following sections. The integration of schema therapy and narrative psychology is schematically summarized in Figure 1, which illustrates how early emotional experiences are translated into schemas, modes, and dominant narrative positions that shape identity.

Narrative Dysfunction in Patients

Under typical developmental conditions, an individual's life story is organized into a relatively coherent narrative that integrates past experiences, supports orientation in the present, and enables anticipation of the future. This narrative organization provides continuity of identity and serves as a central framework for meaning-making (McAdams 2001). When development is disrupted by repeated trauma, chronic neglect, or the long-term frustration of basic emotional needs, this integrative function of narrative organization is often compromised. The life story may become fragmented, discontinuous, or rigid, losing its capacity to organize experience into a coherent whole.

Patients with severe early trauma frequently describe their life histories in a fragmented and non-linear manner, characterized by gaps, abrupt temporal shifts, and difficulty linking discrete episodes into meaningful sequences (Chu *et al.* 1999). Rather than being integrated as autobiographical memories ("something that happened to me in the past"), traumatic experiences persist as ongoing emotional states, bodily reactions, or intrusive images that are repeatedly activated in present situations. This disruption of narrative continuity undermines the stability of narrative identity and weakens the individual's capacity for reflective self-representation.

Narrative dysfunction is particularly pronounced in personality disorders. Salvatore *et al.* (2004) demonstrated that individuals with personality pathology often remain at lower levels of narrative organization, showing a limited capacity to construct complex narratives that connect past, present, and future. Their stories tend to be rigid, repetitive, and narrowly focused on threat, failure, or loss, with minimal access to alternative perspectives or counterbalancing experiences. Gonçalves *et al.* (2016) describe such configurations as problem-saturated stories, in which the dominant problem organizes the entire narrative field while

moments of competence, support, or resilience remain marginalized or absent. These narrative structures reinforce maladaptive schemas and constrain the individual's perceived range of possible actions and meanings.

A central contributor to narrative dysfunction is the presence of internalized parental introjects and critical voices that function as authoritative narrators within the patient's story. These voices, often corresponding to punitive or demanding parenting styles, continuously interpret experience through lenses of blame, inadequacy, and moral failure (Young *et al.* 2003). Empirical research indicates that such internal voices play a key role in shaping negative self-representations and maintaining chronic shame and guilt (Dimaggio *et al.* 2007). As a result, the patient's narrative becomes dominated by rigid evaluative judgments, while perspectives of understanding, compassion, and contextualization remain largely inaccessible.

In borderline personality disorder, narrative organization is often marked by rapid shifts between incompatible narrative positions. The Vulnerable Child, Punitive Critic, and Detached Protector may alternately assume the role of narrator, leading to abrupt changes in perspective and emotional tone (Soroko 2013). This instability prevents the formation of a coherent and unified self-story and contributes to identity diffusion, affective dysregulation, and interpersonal instability. Therapeutic work therefore focuses on identifying these competing narrative positions, externalizing their functions, and gradually integrating them within a broader, more coherent narrative framework.

The aim of narrative-focused intervention is not to eliminate pain, failure, or trauma from the life story, but to situate these experiences within a narrative that allows for recognition of unmet needs, acceptance of vulnerability, and the emergence of agency and hope. Through this process, patients can begin to relate to their past from a more reflective and compassionate position, creating the conditions for identity-level change and strengthening of the Healthy Adult mode (Edwards 2022; Young *et al.* 2003).

Taken together, these forms of narrative dysfunction illustrate why symptom-focused or purely cognitive interventions are often insufficient in patients with complex trauma and personality pathology. When maladaptive schemas are embedded in rigid or fragmented personal stories, therapeutic change requires not only modification of beliefs or behaviors but also a transformation of the narrative structures through which experience and identity are organized. This perspective provides the conceptual basis for understanding narrative processes as core mechanisms of change within schema therapy. In the present work, this perspective is grounded primarily in patients with personality disorders and complex trauma-related conditions treated in individual and group schema therapy programs. Extrapolation to other diagnostic populations (e.g., anxiety or mood disorders without significant early trauma) should therefore be considered a working hypothesis, and adaptations may be necessary when narrative dysfunctions and mode structures differ.

NARRATIVE PROCESSES IN SCHEMA THERAPY

Schema therapy is a psychotherapeutic approach that implicitly and explicitly engages with the patient's personal narrative as a central carrier of meaning, identity, and change. Early maladaptive schemas and their momentary manifestations in schema modes are not merely intrapsychic structures; rather, they are embedded in the stories patients tell about themselves, others, and the world. These stories shape how experiences are interpreted, which roles patients assign to themselves in relationships, and what possibilities for change they perceive as available.

From a clinical perspective, the narratives of patients with more complex presentations are often rigid, fragmented, or saturated with negative meanings. Recurrent motifs of failure, threat, rejection, or shame dominate the story, while alternative perspectives and resources remain inaccessible. Schema activation is therefore expressed not only through emotional reactivity or maladaptive behavior but also through the automatic activation of familiar narrative scenarios dominated by specific positions, such as the Vulnerable Child, the Punitive Critic, or the Detached Protector. Patients find themselves repeatedly inhabiting the same story without sufficient distance to reflect on or modify it.

Narrative processes in schema therapy can be conceptualized as a set of therapeutic mechanisms that render these rigid stories accessible, externalized, and open to transformation. Therapeutic change involves more than correcting dysfunctional beliefs or learning new coping strategies. At its core, it entails the reconstruction of meaning—transforming how patients understand their past, interpret their present experiences, and imagine their future. A central element of this process is the recognition of originally frustrated emotional needs and the emergence of new narrative positions, most notably those associated with the Healthy Adult and the Kind Parent modes (Young *et al.* 2003; Edwards 2022).

Schema therapy employs several experiential techniques with strong narrative potential. These methods operate across multiple levels of experience, including imagery, emotion, bodily sensation, internal dialogue, and symbolic representation. By enabling patients not only to relive but also to retell key experiences in ways that include protection, validation, and adult agency, these interventions support the gradual construction of a more coherent and compassionate personal narrative. In the following sections, the principal narrative-oriented techniques used in schema therapy are described in detail, together with their theoretical

grounding, clinical application, and mechanisms of change.

Imagery Rescripting (ImR)

Imagery Rescripting (ImR) represents one of the core experiential techniques of schema therapy and targets emotionally charged autobiographical memories that serve as key carriers of early maladaptive schemas (Çili & Stopa 2021; Ociskova *et al.* 2022a). Rather than focusing on cognitive reinterpretation alone, ImR directly engages emotional memory systems by reactivating developmentally significant scenes in which basic emotional needs, such as safety, protection, acceptance, and validation, were chronically frustrated (Arntz 2012). From a narrative perspective, these memories function as foundational scenes that organize the patient's life story and repeatedly shape self-representation, relational expectations, and affective responses (Prasko *et al.* 2025).

The ImR process typically unfolds in structured phases that correspond to distinct narrative positions. Initially, the patient is guided to re-enter the target memory from the perspective of the child self, allowing access to the original emotional, bodily, and perceptual experience. This phase activates the dominant narrative position of the Vulnerable Child and brings implicit meanings, often organized around shame, fear, or helplessness, into conscious awareness (Prasko *et al.* 2024b). In the subsequent phase, a shift in narrative position is facilitated: the adult self, or another protective figure, enters the scene and actively responds to the situation. This intervention may involve setting boundaries toward abusive figures, providing comfort, or explicitly articulating validation of unmet needs and protection (Prasko *et al.* 2025). In the final phase, the memory is reshaped so that the child's unmet needs are symbolically fulfilled, and the scene concludes with a sense of safety, dignity, and relational support.

Crucially, ImR does not aim to negate or invalidate historical reality. Instead, it embeds the original experience within a new narrative framework that includes agency, protection, and meaning. The traumatic event remains acknowledged as part of the life story, but its emotional significance and narrative function are fundamentally altered (Arntz 2012; Recher *et al.* 2024). From the standpoint of narrative identity, this process enables a transition from being immersed *inside* the traumatic story as a powerless child to becoming the *author* of the story as an adult capable of reflection and care.

Empirical evidence supports the clinical effectiveness of ImR across a range of conditions, including post-traumatic stress disorder, borderline personality disorder, and nightmare-related sleep disturbances (Arntz 2012; Kunze *et al.* 2016). Beyond symptom reduction, experimental studies indicate that ImR can be associated with measurable changes in emotional memory processing and may facilitate the integration of previously fragmented memory traces into autobiographical memory (Recher *et al.* 2024). Within contemporary models of memory reconsolidation, ImR can be understood as a targeted reactivation of an emotional memory trace followed by its updating with new affective and relational information. This reconsolidation process may alter the implicit meanings associated with the memory, thereby potentially reducing its capacity to automatically trigger maladaptive schemas and modes in present situations.

From a clinical and narrative perspective, the transformative potential of ImR lies in its capacity to reorganize the patient's personal story at a foundational level. By repeatedly experiencing oneself as protected, validated, and emotionally accompanied within previously traumatic scenes, patients gradually internalize new narrative positions associated with the Healthy Adult and the Kind Parent modes. These positions then become available not only within the therapeutic context but also in everyday life, supporting greater self-coherence, emotional regulation, and flexibility in relationships. In this sense, ImR exemplifies how narrative-oriented interventions in schema therapy operate as mechanisms of identity-level change rather than isolated symptom-focused techniques.

Case Study: ImR in a Patient with Anxiety and Feelings of Inadequacy

Jana, a 28-year-old woman, entered psychotherapy due to long-standing generalized anxiety, heightened sensitivity to criticism, and pervasive feelings of personal inadequacy. She described herself as compliant and conflict-avoidant in interpersonal situations, particularly in professional settings, where even minor feedback was experienced as deeply threatening. Internally, her emotional life was dominated by harsh self-criticism, persistent shame, and anticipatory anxiety. Although outwardly functioning, Jana reported chronic inner tension and exhaustion resulting from constant self-monitoring and fear of making mistakes.

Schema-therapeutic assessment identified prominent activation of the Defectiveness/Shame schema and the Emotional Deprivation schema, with frequent shifts into the Vulnerable Child mode in response to perceived criticism, followed by the Punitive Parent mode characterized by internal accusations ("You're incompetent," "You should have known better"). Adaptive modes, particularly the Healthy Adult, were weak and difficult for Jana to access spontaneously.

Across several sessions, a recurrent childhood memory emerged as emotionally central. Jana described an incident from early school age, when she was seven years old and received a poor grade at school. Her father responded with harsh verbal criticism, raising his voice and accusing her of laziness and failure. He then sent her alone to her bedroom, turned off the light, and left her there for an extended period. Jana recalled sitting in the dark, frozen with fear, convinced that she had fundamentally failed and that no one would come to help her. The memory was accompanied by intense bodily sensations—tightness in the chest, shallow breathing, and a sense of inward collapse—which

closely resembled her current anxiety reactions in adult situations involving evaluation.

ImR Process

During the ImR session, Jana was first guided to re-enter the scene from the perspective of her child self. She described herself sitting on the edge of the bed, knees drawn to her chest, eyes fixed on the door. Her voice became quieter, and her speech slowed. Cognitions characteristic of the activated schema emerged spontaneously: "Nobody wants me," "I ruined everything again," "I must not make any noise." Emotionally, fear and shame were dominant; behaviourally, the child remained immobile and withdrawn.

In the next phase, Jana was invited to allow a protective figure to enter the scene. Without suggestion, her grandmother appeared—an important attachment figure from her childhood, remembered as calm and emotionally available. In the imagery, the grandmother entered the dark room, switched on the light, and approached the child. Jana described a decisive moment in which the grandmother positioned herself physically between the child and the father, saying in a firm voice: "You will not frighten her like this. She is a child, not a failure." She then turned to Jana, knelt down to her level, and said: "You are not bad. One grade does not define who you are. You deserve to be safe, and you are not alone."

As the scene unfolded, Jana reported a marked shift in her bodily state. The tension in her chest softened, her breathing slowed, and a sensation of warmth spread through her upper body. Emotionally, fear gave way to relief and calm, affective states that she had never previously associated with this memory. After the imagery concluded, Jana said quietly: "For the first time, someone stayed with me. I didn't have to disappear."

Transfer to Current Functioning

In subsequent sessions, Jana reported spontaneous recall of the rescripted scene during moments of perceived criticism at work. Although anxiety still arose, it was less overwhelming and no longer immediately accompanied by harsh self-attacks. Instead, she described an emerging capacity to internally "pause," recognize her fear, and respond with greater self-protection. The previously dominant punitive inner voice became less absolute, and a new internal response—described as "a calmer, adult part that reminds me I'm allowed to make mistakes"—began to appear.

Analytical Examination of the Therapeutic Process

From a schema-therapeutic perspective, the ImR activated the full schema network associated with Defectiveness/Shame, including its cognitive, emotional, somatic, and behavioral components. The critical transformation occurred at the moment when a protective figure entered the narrative and explicitly addressed the child's unmet needs for safety and validation. This intervention disrupted the original implicit meaning structure of the memory ("I am bad and alone") and replaced it with a new core meaning ("I deserve protection and care").

From a narrative perspective, the intervention enabled a shift in narrative position: Jana moved from being embedded within the traumatic scene as a powerless child to occupying an authorial position that allowed the scene to be reinterpreted and completed differently. The memory ceased to function solely as a shame-saturated origin story and became a revised narrative episode that included relationship, protection, and agency. This narrative transformation expanded the repertoire of available internal voices and weakened the dominance of the punitive introject.

At the level of emotional memory, the rescripting process can be understood as reactivation followed by reconsolidation of the autobiographical memory with new affective and relational content (Recher *et al.* 2024). This mechanism may help to explain the observed generalization of therapeutic effects to present-day situations. Rather than relying on conscious reappraisal alone, Jana's responses to criticism changed because the emotional meaning of the original memory, and its role within her life story, had been fundamentally altered.

Overall, this case illustrates that the clinical efficacy of ImR lies not merely in emotional release, but in its capacity to reorganize the patient's narrative identity. By embedding corrective experiences within key autobiographical scenes, schema therapy facilitates identity-level change that supports greater self-coherence, self-compassion, and resilience over time.

Chairwork

Chairwork is a central experiential technique within schema therapy that enables the explicit externalization and dialogical processing of internal conflicts. It is grounded in the assumption that psychological distress is not merely the result of dysfunctional beliefs, but also emerges from dynamic interactions between relatively autonomous parts of the self, each with its own emotional tone, motivational agenda, and narrative voice (Kellogg & Young 2006). Chairwork translates these intrapsychic processes into the interpersonal space of therapy, where they can be observed, experienced, and actively modified (Ociskova *et al.* 2022b).

Within schema therapy, chairwork is most commonly applied to working with schema modes, including vulnerable child modes (e.g., Vulnerable Child), internalized parental modes (Punitive or Demanding Critic), maladaptive coping modes (e.g., Detached Protector), and adaptive modes such as the Healthy Adult and the Kind Parent. By physically moving between chairs, the patient temporarily inhabits different perspectives, allowing shifts in posture, affect, language, and meaning to emerge naturally. This embodied perspective-taking disrupts habitual, automatic patterns of self-experience and makes previously implicit internal dialogues explicit and accessible to reflection.

Empirical research indicates that chairwork often increases emotional activation, facilitates access to maladaptive schemas, and enhances the likelihood of corrective emotional experiences (Kellogg & Young 2006; Arntz & Jacob 2013). However, its therapeutic value extends beyond emotional intensity. From a narrative standpoint, chairwork can be conceptualized as a structured method for *deconstructing a rigid personal story into its constituent voices and roles*. Each chair represents a distinct narrative position, such as the

Critic, the Vulnerable Child, or the Detached Protector, which contributes to the overall plot through which the patient understands themselves and their relationships.

In many patients, particularly those with personality disorders or complex trauma histories, one narrative position tends to dominate the internal story. Often the punitive or shaming voice is dominating, while other perspectives remain marginalized or silenced. Chairwork allows these suppressed or underdeveloped voices—most notably the Healthy Adult and the Kind Parent—to be explicitly articulated and strengthened. Through guided dialogue, the patient can confront destructive voices, articulate unmet needs, and gradually introduce alternative interpretations that acknowledge vulnerability without collapsing into self-condemnation.

Crucially, chairwork enables a shift in *narrative agency*. Rather than being fully identified with a single internal voice, the patient begins to experience themselves as someone who can move between positions, observe them, and mediate their interaction. This meta-position is conceptually similar to Kind Parent and the Healthy Adult mode and represents a fundamental change in how the patient relates to their inner experience. The internal story is no longer a monologue dominated by criticism or fear, but becomes a dialogue in which protection, validation, and realistic reflection are possible.

From the perspective of narrative identity, chairwork thus supports the integration of previously dissociated or conflicting self-states into a more coherent and flexible story. Painful emotions and self-critical judgments are not eliminated, but are repositioned within a broader narrative framework that allows for complexity, compassion, and choice. In this sense, chairwork functions as a powerful narrative intervention that transforms internal dialogue into a space for meaning-making and identity reconstruction, laying the groundwork for sustained change beyond the therapy room.

Case Study: Chairwork in a Patient with Chronic Self-Criticism

Petr, a 35-year-old man, entered therapy due to long-standing feelings of inadequacy, chronic work overload, and recurrent episodes of burnout. He was professionally successful and perceived by others as reliable and competent; however, subjectively, he experienced constant inner pressure, tension, and dissatisfaction. He described living "as if someone inside were constantly evaluating me," with even minor mistakes triggering intense self-criticism and anxiety. Despite external achievements, he reported little sense of satisfaction or self-worth.

Schema-therapeutic conceptualization indicated a dominant Relentless Standards schema intertwined with the Defectiveness/Shame schema. At the mode level, a highly active Punitive Critic mode was evident, accompanied by overcompensatory coping strategies involving excessive performance and responsibility-taking. Vulnerability and emotional needs were largely suppressed, with the Vulnerable Child mode remaining present but rarely consciously acknowledged.

Chairwork Process

The chairwork intervention was introduced after sufficient stabilization and once a therapeutic alliance had been established. Three chairs were arranged in the room, representing the Vulnerable Child, the Punitive Critic, and the Healthy Adult.

Vulnerable Child Chair

When Petr was invited to sit in the Vulnerable Child chair, his posture visibly changed. He leaned forward, shoulders collapsed, and his gaze dropped to the floor. His voice became quieter and hesitant. After a brief pause, he addressed his father, who was symbolically represented in the empty space opposite him:

"Dad, I tried. I really did everything you wanted. I studied, I worked hard, I didn't complain. But it was never enough. You always found something wrong."

As he continued, his speech slowed and his breathing became shallow. Emotionally, sadness and helplessness dominated; physically, he reported tightness in his chest and a lump in his throat.

"I was scared all the time," he added softly. "I felt that if I stopped trying, you would stop caring."

This phase made explicit a narrative position in which Petr experienced himself as a perpetually failing child, whose worth depended entirely on performance and compliance.

Punitive Critic Chair

When Petr moved to the Punitive Critic chair, his posture straightened immediately. His voice became firmer, sharper, and more authoritarian. Without hesitation, he addressed the Vulnerable Child:

"You are not enough. If you relax, you will fail. Others will surpass you. You must try harder. There is no room for weakness."

As he spoke, Petr noticed how familiar these sentences felt. He commented spontaneously, "This is exactly what I tell to myself every day." The therapist reflected that this voice functioned as an internalized parental narrator, enforcing rigid standards while disregarding emotional needs.

The dialogue between the two chairs revealed a closed narrative loop: relentless demands followed by exhaustion, shame, and renewed self-attack.

Healthy Adult Chair

In the final phase, Petr was invited to sit in the Healthy Adult chair. Initially, he hesitated and asked for a moment to breathe. After grounding himself, he spoke more slowly and deliberately, directing his words to both previous positions:

"You were a child," he said, turning toward the Vulnerable Child chair.

"Children do not need to be perfect to deserve love. They need safety, encouragement, and someone who stands by them."

He then addressed the Punitive Critic:

"Your way of motivating is harsh. It kept me functioning, but it also kept me scared and exhausted. I don't need you to be this cruel anymore."

After a pause, Petr added quietly:

"My father didn't know how to support me another way. But today, I can choose to treat myself differently. I can work and rest. I can make mistakes and still have value."

At this moment, Petr reported a marked bodily shift: his shoulders relaxed, his breathing deepened, and the tension in his chest eased. He stated:
"This is the first time I feel that I don't have to earn my right to exist."

Changes Following the Intervention

In subsequent sessions, Petr reported increased awareness of the punitive voice in everyday situations, particularly at work. Although the critical voice did not disappear, he was increasingly able to recognize it as just one internal position rather than an absolute truth. He began experimenting with setting limits at work, taking breaks without excessive guilt, and responding to mistakes with less self-attack. These behavioral changes were accompanied by a gradual reduction in emotional exhaustion and an improved subjective well-being.

Analytical Examination of the Therapeutic Process

From a schema therapy perspective, chairwork enabled the clear externalization of a previously fused internal experience. Petr's self-criticism had been experienced as an unquestionable inner reality; the spatial separation of the modes allowed him to recognize the Punitive Critic as an internalized voice with a specific developmental origin and function, rather than an objective evaluator. This significantly weakened its authority.

The key therapeutic shift occurred through the activation and strengthening of the Healthy Adult mode. Importantly, this mode did not merely counter the Punitive Critic cognitively, but simultaneously validated the vulnerability of the Vulnerable Child and set firm boundaries toward the internalized demands. This dual function—protection and limit-setting—is central to corrective emotional experience within schema therapy (Arntz & Jacob 2013).

From a narrative perspective, chairwork facilitated a fundamental change in narrative position. Petr moved from being embedded within a rigid story dominated by performance and failure to adopting the role of an observing and authoring self. The internal narrative shifted from a monologic structure ("I must be perfect or I am nothing") to a dialogical one, in which multiple voices could be acknowledged, negotiated, and integrated.

This reorganization of internal dialogue represents more than emotional catharsis. It reflects a restructuring of narrative identity, in which self-worth is no longer defined solely by achievement. The emergence of the Healthy Adult as a narrative mediator allowed Petr to construct a new story about himself—one that includes vulnerability, limits, and inherent value. Such narrative integration provides a plausible mechanism for the observed transfer of therapeutic change into daily functioning and supports the long-term stability of therapeutic outcomes.

Therapeutic Letters

Therapeutic letter writing is a narrative-based intervention that integrates experiential processing, externalization, and structured reflection on relational experiences. Within schema therapy, letters are used both to address significant figures from the patient's past and to work directly with internalized parts of the personality, particularly critical and parental introjects (Prasko *et al.* 2024b). The primary aim of this technique is to enable patients to articulate emotions, needs, and meanings that could not be expressed within the original relational context.

Unlike spontaneous verbal expression, letter writing introduces temporal distance and cognitive containment. The act of writing slows the internal dialogue, promotes reflective processing, and allows patients to regulate the level of emotional exposure. The written text functions as a transitional object, mediating contact with emotionally charged material while maintaining a sense of safety and control. This makes therapeutic letters particularly suitable for patients with high levels of shame, inhibition, or fear of confrontation.

From a narrative perspective, therapeutic letters facilitate a shift in narrative position. Patients move from a passive role, defined by unspoken suffering or internalized judgment, to an active authoring stance in which they can name injustice, express unmet needs, and redefine relational meanings. Importantly, the past is not altered; rather, its interpretation and narrative framing are transformed, allowing for greater coherence and self-compassion.

Case Study: Therapeutic Letters and Reframing the Relationship to the Parental Introject

Veronika, a 31-year-old woman, entered group schema therapy for recurrent depressive episodes, persistent feelings of worthlessness, and pronounced self-criticism. In interpersonal relationships, she tended to adapt excessively, suppress her own needs, and avoid conflict. Internally, her experience was dominated by a harsh, evaluative inner voice that constantly monitored her performance and moral adequacy. Schema-therapeutic conceptualization identified the Defectiveness/Shame and Emotional Deprivation schemas as central, with frequent activation of a Punitive Critic mode internalized from her relationship with her mother.

Veronika described her mother as emotionally distant, highly critical, and strongly performance-oriented. Expressions of warmth, affection, or pride were rare, whereas mistakes were quickly highlighted and often accompanied by ridicule or comparison with others. Throughout childhood and adolescence, Veronika learned that acceptance was conditional and had to be earned through compliance and achievement. In therapy, this history repeatedly condensed into core beliefs such as "There is something fundamentally wrong with me" and "I must try harder to deserve being accepted."

Uncensored Letter

As part of the therapeutic process, Veronika was invited to write an uncensored letter to her mother. She was explicitly instructed that the letter was not meant to be sent and that its purpose was not for reconciliation, but for expression. The task emphasized writing without self-censorship and giving voice both to the child who had been silenced and to the adult who could now reflect on what had been missing.

In the letter, Veronika wrote:

"Mom,
You never really saw the real me. You looked at me, but you didn't notice who I was. You mostly noticed what I did wrong—my mistakes, my failures, the moments when I disappointed you. When I was happy, excited, or proud of myself, you were silent. My joy seemed invisible to you, as if it did not matter or did not deserve attention.
Growing up, I constantly felt like the worst one. Like I was always one step behind, always lacking something essential. I learned very early that love had conditions. That I had to behave better, try harder, be quieter, more successful, more perfect. Even then, it was never enough. No matter how hard I tried, I felt that I was failing some invisible test.
I needed to hear that you loved me. Not because I did something right. Not because I achieved something. Just because I was your child. I needed to hear that I mattered, that I was enough, that I didn't have to earn my place. But I never heard that. Instead, I learned to doubt myself, to be ashamed of my needs, and to believe that something was wrong with me.
I carried this voice with me into adulthood. Your criticism became my own. I judge myself the way you judged me. I push myself, punish myself, and feel guilty whenever I am not perfect. I live as if someone is always watching me, evaluating me, waiting for me to fail.
Today, I want to say something that I could not say as a child. I was a child. I was sensitive. I needed warmth, safety, and acceptance. I had the right to make mistakes and still be loved. What I missed was not discipline or pressure, but protection, kindness, and reassurance. I am writing this not to accuse you, but to finally give a voice to the child who stayed silent for so long. I want to stop carrying this pain inside me. I want to live my life without constantly trying to prove that I deserve to exist."

Reading the letter aloud in the group was emotionally intense. Veronika cried, her voice trembled, and she paused repeatedly to regulate her breathing. At the same time, she described a sense of relief and physical lightness, stating that "the words finally came out instead of staying inside and turning against myself."
Group members responded with visible empathy. Several shared similar experiences with critical parents, while others offered brief validating statements such as "What you went through was painful" or "You didn't deserve that as a child." This collective response significantly reduced Veronika's shame and strengthened her sense of belonging.

Letter from the Other Side

In a subsequent phase, the therapist introduced a complementary task: writing a letter from the other side—a symbolic response that would express what Veronika had needed to hear in childhood. Initially, she resisted, stating that "it feels fake" and "my mother would never say this." After careful framing, the task was redefined not as a realistic representation of the mother, but as a narrative construction aimed at fulfilling unmet emotional needs.
The letter read:

"My dear child,
I want to say the words you needed to hear, even though you never heard them when you were young. I am sorry that I did not protect you. I am sorry that I looked at you through the lens of performance instead of seeing who you truly were.
You were not difficult. You were not too sensitive. You were not a disappointment. You were a child who needed understanding, encouragement, and safety. Instead of giving you that, I measured you by what you did and what you achieved. I failed to notice your fear, your loneliness, and how hard you were trying just to be good enough.
I am sorry that my criticism became louder than my care. I am sorry that my silence made you believe you were invisible. You should never have felt that love had to be earned. You never had to be perfect to deserve it.
You were sensitive because you were alive. You were trying because you cared. You were worthy of love simply because you existed. Nothing was wrong with you.
I want you to know that you have the right to rest. You have the right to say no. You have the right to have needs and feelings without feeling ashamed. You do not have to prove anything anymore.
I see you now. I see your strength, but I also see your vulnerability. And both are allowed. You deserve kindness, from others, and from yourself."

When reading this letter, Veronika reported mixed emotions and sadness for what had been missing, but also calm and sense of relief. She noted that "for the first time, the voice in my head did not sound accusing."

Development and Transfer

In the following sessions, Veronika described increased awareness of the critical inner voice and a growing ability to distinguish it from her own perspective. While the self-critical voice did not disappear entirely, it lost its absolute authority. She began to respond to it with greater distance and self-compassion and reported small but significant behavioral changes, such as setting clearer boundaries at work and expressing disagreement without feeling immediate guilt.

Analytical Examination of the Therapeutic Process

From a schema therapy perspective, therapeutic letters enabled the externalization of the Punitive Critic mode, which had previously functioned as the dominant narrator of Veronika's identity. The uncensored letter disrupted the automatic internal alignment with this voice and created a clear boundary between the historical mother and the internalized introject. This weakened the schema-driven assumption that self-criticism represented an objective truth.
From a narrative perspective, the intervention facilitated a decisive shift in narrative position. Veronika moved from the role of a silently enduring child to that of an adult author who could name injustice, articulate unmet needs, and redefine the meaning of past experiences. The letter from the other side introduced a new narrative voice—functionally corresponding to the Kind Parent—which expanded the internal narrative repertoire and allowed for alternative interpretations of self-worth to emerge.
The group context played a crucial amplifying role. Group responses functioned as externalized supportive voices, providing a corrective relational experience that reinforced the

legitimacy of Veronika's story. Through this process, her narrative identity shifted from a story of deficiency and conditional acceptance to one that included recognition, validation, and the right to have needs.

Overall, this case illustrates how therapeutic letters operate at the intersection of schema therapy and narrative change. Their effectiveness lies not only in emotional expression, but in the restructuring the narrative architecture of identity. They transform who speaks internally, from which position, and with what authority.

River of Life Method

The River of Life method employs the metaphor of a river as a visual–narrative framework through which patients organize their life story across time. Significant events, relational experiences, turning points, obstacles, and sources of support are represented symbolically along the river's course. Within schema therapy, this method facilitates the integration of fragmented autobiographical material into a temporally coherent and meaningful narrative, allowing patients to perceive their life not merely as a series of isolated traumatic episodes but as a continuous developmental process that also includes relationships, resources, and moments of mastery (Prasko *et al.* 2024a).

From a narrative perspective, the River of Life supports a shift from problem-saturated stories toward more differentiated and flexible narratives. The river metaphor enables patients to contextualize adverse experiences as parts of a broader life trajectory, one that may narrow, accelerate, or encounter obstacles, yet continues to flow and is shaped by tributaries and surrounding banks. This promotes the development of a meta-narrative position, from which patients can reflect on, reinterpret, and supplement their story with alternative meanings, rather than remaining rigidly identified with a single traumatic interpretation of the self.

Within the schema therapy framework, the River of Life provides a bridge between narrative organization and the concepts of schemas and modes. Recurrent patterns depicted in the River of Life, such as abandonment, loneliness, excessive responsibility, or lack of support, can be understood as symbolic expressions of early maladaptive schemas. The manner in which patients describe specific sections of the river reflects currently active modes, including the Vulnerable Child, Detached Protector, or internalized parental voices that impose guilt, obligation, or self-blame. Therapeutic work does not aim to eliminate these elements but to integrate them into a broader narrative in which the perspective of the Healthy Adult becomes increasingly available.

A distinctive strength of the River of Life method lies in its relational dimension, particularly in group schema therapy. Sharing a visually externalized life story facilitates validation, normalization, and the reduction of shame, while enabling corrective relational experiences to occur not only within the therapist–patient dyad but also through the group. Responses from other group members often function as externalized voices of the Kind Parent and Healthy Adult, which patients may gradually internalize. As a result, the method contributes not only to the re-meaning of specific memories, but also to a more compassionate and coherent overall narrative identity.

Case Study: River of Life in Group Schema Therapy – Transforming the Rigid Narrative "I Must Be Strong"

Marie, a 40-year-old woman, participated in a closed group schema therapy program for patients with chronic depressive symptoms, emotional exhaustion, and long-standing difficulties in close relationships. Her clinical history was marked by pronounced emotional loneliness in childhood and the premature assumption of responsibility within the family system. Marie repeatedly stated that she "cannot rely on anyone" and that in demanding situations she automatically assumes the role of the one who must manage everything alone. Schema-therapeutic conceptualization identified prominent Emotional Deprivation and Relentless Standards schemas, with frequent activation of the Vulnerable Child and Detached Protector modes.

Construction of the River of Life

As part of the group intervention, the River of Life method was introduced. Each participant was given a large sheet of paper and invited to draw their life as a river flowing from early childhood to the present. The emphasis was placed on subjective meaning rather than chronological precision. Patients were encouraged to use symbols, words, and the spatial arrangement to capture emotionally significant moments, obstacles, and sources of support.

Marie worked in silence for a prolonged period. She drew a river that flowed calmly during early childhood, with wide banks and smooth curves. Around the age of nine, however, the river suddenly narrowed and sharp rapids appeared. At this point, she placed a large, dark stone directly in the middle of the river and wrote on it: "Parents' divorce." Along the riverbank next to this stone, she added a handwritten note: "Mom couldn't cope, so someone had to be strong." Visually, this section dominated the entire drawing and appeared to constrict the flow of the river beyond it.

Group Sharing and Emotional Activation

During the group sharing phase, Marie focused almost exclusively on this section of the river. Her voice became quieter and more controlled as she explained that after the divorce, she felt responsible for her mother's emotional stability and believed she had no right to express her own fear or sadness. When the therapist asked what she had needed most at that time, Marie paused for a long moment and then said softly: "For someone to tell me it wasn't my fault. And for someone to protect me."

This moment was accompanied by a strong emotional reaction. Marie began to cry and quickly apologized for "being too emotional," which clearly reflected the activation of the Vulnerable Child mode combined with a strong internal

demand for emotional control associated with the Detached Protector mode.

Corrective Relational Intervention

The therapist invited the group to participate in a symbolic corrective response. One group member was supported in taking the role of the Kind Parent and addressing Marie directly. In a calm and steady voice, he said:

"Marie, you did not have to take care of adults. You were a child. The divorce was not your responsibility. You deserved protection and care."

Marie responded with intense crying and after a pause stated: "No one ever said that to me. I believed my whole life that if I wasn't strong, everything would collapse." This exchange represented a clear corrective emotional experience, mediated not only by the therapist but also by the group as a relational container.

Expanding the Narrative: Identifying Tributaries

In the next phase, Marie was invited to return to her drawing and search for at least one tributary—any source of support that had existed during that difficult period, however small. Initially, she resisted, stating that "there was no one." After some time, she recalled a childhood memory of a classmate who often stayed with her after school and occasionally walked her home. She added a small tributary to the river, labeling it "Eva – after school." While doing so, she commented: "At least someone was there."

At the end of the sharing, Marie articulated a new narrative meaning: "Maybe I was strong because I had to be, but I don't have to be strong all the time anymore."

Transfer to Daily Life

In subsequent weeks, Marie reported that she repeatedly returned to the image of her river, especially during moments of stress. Importantly, she no longer focused solely on the stones and rapids but increasingly noticed the tributaries. Clinically relevant changes followed: she began asking her partner for help, allowed herself to express fatigue, and described feeling less emotionally isolated.

Brief Analytical Examination of the Therapeutic Process

From an analytical perspective, the River of Life method facilitated narrative integration on multiple levels. The large-format visual representation externalized Marie's rigid self-concept and enabled psychological distance from the dominant narrative of compulsory strength. The parental divorce, which had previously been a defining traumatic moment, ceased to function as an isolated, identity-defining point and became embedded within a broader temporal and relational context.

The group-based corrective relational experience played a central role. The externalized Kind Parent voice provided validation and protection in a manner difficult to achieve through purely intrapsychic techniques. This voice subsequently became available for internalization, strengthening the Healthy Adult mode. Equally important was the identification of tributaries, which disrupted the problem-saturated narrative of "I was always alone" and introduced narrative flexibility.

From a narrative schema therapy perspective, this intervention enabled a shift in narrative position: from a story dominated by obligation and emotional suppression toward a more compassionate and differentiated life story. By integrating timeline, emotional meaning, relational experience, and group support, the River of Life functioned as a highly integrative narrative intervention. Its capacity to connect these levels makes it a particularly powerful method for identity-level change and long-term modification of inner dialogue within schema therapy (Prasko *et al.* 2024a).

Inner House Method

The Inner House method is a narrative–experiential intervention in which patients create a tangible, spatial representation of their inner world through a symbolic house. Unlike purely imaginative techniques, the house is physically constructed from paper boxes that are glued and stacked vertically, forming a structure with a ground floor, a first floor, and a second floor. This material construction is therapeutically important: it allows patients literally *build* their inner world, observe it from the outside, and actively reorganize it.

Each floor symbolically represents different layers of life experience and psychological functioning. Patients place small objects, figurines, therapeutic cards, drawings, written labels, or symbolic items, into the individual floors to express the emotional atmosphere and dominant themes of each level. The focus is not on aesthetic quality but on meaning. Each object functions as a narrative marker, representing a relational experience, a schema, or a schema mode. The house thus becomes a three-dimensional narrative that simultaneously captures past experiences, current functioning, and internal dynamics.

From a narrative perspective, the Inner House method supports the organization of an often fragmented and chaotic inner world into a structured story with spatial logic and continuity. The physical layout promotes a meta-position: patients are no longer fully immersed within their story but can step back, describe it, and gradually modify it. This perspective naturally aligns with the schema therapy concept of modes, as different parts of the house can be "inhabited" by different modes that may coexist, conflict, or dominate specific areas of the inner space.

Within schema therapy, the Inner House method is particularly valuable because it makes relationships between parts of the personality visible and real. Patients can directly observe which areas of their Inner House are neglected, overcrowded, rigidly controlled, or emotionally inaccessible. The Healthy Adult and the Kind Parent are not abstract constructs but can be represented by concrete figures that move through the house, pause at specific floors, and respond to their emotional climate. Therapeutic change thus occurs through symbolic reorganization of inner space rather than through cognitive correction alone.

In group schema therapy, the Inner House method substantially strengthens the relational dimension of the work. Sharing a physically constructed house enables

other group members to access the patient's inner world in a concrete, comprehensible, and emotionally resonant way. Group responses often function as externalized supportive voices, reducing shame and reinforcing the experience that the patient's inner story is legitimate, meaningful, and worthy of attention.

Case Study: Building an Inner House in a Group– Sofia's Story

Sofia, a 34-year-old woman, was enrolled in group schema therapy for long-standing anxiety–depressive symptoms, chronic exhaustion, and marked difficulties in asserting her own needs. In interpersonal relationships, she tended to adapt excessively, avoid conflict, and suppress negative emotions, which often led to emotional overload and bodily tension. Schema-therapeutic conceptualization identified dominant Subjugation and Emotional Deprivation schemas, with frequent activation of the Vulnerable Child and Detached Protector modes.

The Inner House method was introduced within a small therapy group consisting of three patients. Sofia began by physically constructing her house from prepared paper boxes. She carefully glued the boxes on top of each other to form a ground floor, a first floor, and a second floor. While working, she repeatedly emphasized that the house "has to be stable so it doesn't collapse." The therapist reflected on this comment as symbolically meaningful, linking it to Sofia's long-standing need to maintain inner control and emotional stability at the cost of suppressing her own needs.

On the ground floor, Sofia placed small figurines representing childhood. Next to one of the child figures, she added a card with the word "quiet" and pieces of dark-coloured paper. She explained that these elements captured the atmosphere of frequent parental conflicts during her childhood. She also placed a small image depicting herself sitting alone with her sister in a room. While describing this floor, Sofia stated quietly, "This is where I learned not to bother anyone." Her tone was flat, and she minimized the emotional impact of the scene, indicating the presence of the Detached Protector mode.

The first floor was filled with handwritten notes and symbols expressing internalized rules she followed in adulthood: *"don't be a burden," "hold on," "be good,"* and *"don't ask."* The space appeared crowded and visually overwhelming. Sofia commented, almost jokingly, "There's not much room to breathe here." The therapist invited brief reflections from the group, and the other patients responded with empathetic observations, noting how constrained the space felt. Sofia nodded and said, "Yes, that's how it feels inside all the time."

On the top floor, Sofia placed a figurine symbolizing her current work environment, where she frequently took on additional responsibilities beyond her role. She positioned a figurine labelled *"Subordinate Mode"* on an improvised "throne," visually emphasizing its dominance. The Healthy Adult figurine, by contrast, was placed hesitantly on the staircase between floors. When the therapist asked what would need to change for the Healthy Adult to move upstairs, Sofia paused for a long moment and then replied softly, "I would have to stop being so quiet downstairs."

In the next phase of the intervention, the other group members were invited to symbolically adopt the role of the Kind Parent. One patient looked at Sofia's house and said, "That house deserves more light." Sofia immediately burst into tears and added, "It never occurred to me that I could turn on the light." This moment marked a profound narrative shift. For the first time, Sofia explicitly positioned herself not only as the inhabitant of her inner world, but also as someone who could actively care for it.

In the weeks following the session, Sofia reported that she frequently recalled the image of her house during stressful situations. Visualizing specific floors helped her recognize when she was slipping into submissive or emotionally withdrawn patterns. She described being increasingly able to pause, reflect, and choose responses aligned with the Healthy Adult mode, such as expressing limits at work or asking for support from close others.

Brief Analytical Examination of the Therapeutic Process

From an analytical perspective, the Inner House method enabled Sofia to construct a coherent, spatially anchored representation of an identity that had previously been experienced as diffuse and fragmented. The physical act of building the house from paper boxes enhanced the experience of authorship: Sofia was not merely recounting her story, but was actively creating and organizing it. This material engagement supported a shift from passive immersion in habitual narratives toward a reflective meta-position.

The symbolic arrangement of the floors facilitated the integration of early relational experiences, dominant schemas, and current coping modes into a single narrative structure. Childhood emotional suppression, internalized demands, and present-day subjugation were no longer isolated phenomena but appeared as interconnected layers of one story. From a schema therapy perspective, the visibility of modes within the house allowed Sofia to recognize the dominance of the Subordinate and Detached Protector modes and the marginal position of the Healthy Adult.

The group context provided a crucial corrective relational experience. Supportive reflections from other group members functioned as externalized voices of the Kind Parent, which legitimized Sofia's unmet needs and weakened her feeling of shame. These voices could then be gradually internalized, strengthening the Healthy Adult mode. From a narrative perspective, Sofia's story shifted from one of silent endurance to one that included agency, care, and the possibility of change.

Overall, the Inner House method functioned as a powerful integrative intervention within narrative schema therapy. It enabled Sofia not only to understand her internal structure, but also to begin actively reshaping it. Through symbolic reorganization of inner space, narrative meaning was transformed, supporting identity-level change and more adaptive functioning in everyday life.

Integration into a New Story

Across narrative-oriented techniques in schema therapy, a shared mechanism of change can be identified: the deliberate transformation of the patient's life story at the level of meaning and identity. Therapeutic work consistently aims to reposition the child self; from an internalized image of defectiveness or failure toward an understanding of the child as vulnerable,

legitimate in their needs, and embedded in a context that failed to provide adequate care. This reframing represents a core shift in narrative identity and internal organization.

As new narrative meanings are introduced, the dominance of the Punitive Critic and the Detached Protector gradually weaken. In parallel, the voices of the Healthy Adult and the Kind Parent gain strength and continuity. Patients increasingly learn to respond to present-day challenges with greater emotional regulation, self-compassion, and sensitivity to their own needs; capacities that were previously suppressed or experienced as dangerous. Importantly, this transformation does not occur solely at a cognitive level. It is grounded in corrective emotional and relational experiences that become embedded within the personal narrative.

The integration of these experiences into a coherent autobiographical story supports the durability of therapeutic change. Rather than remaining fragmented or state-dependent, new meanings are consolidated as part of the patient's identity. Patients begin to experience their life story not only as a sequence of trauma, loss, or criticism, but as a narrative that also contains protection, agency, acceptance, and moments of joy. Such narrative flexibility provides a stable foundation for ongoing personal development and reduces vulnerability to relapse (Arntz 2012; Arntz & Jacob 2013; Recher *et al.* 2024).

An overview of the principal narrative techniques used in schema therapy, their primary focus, core mechanisms of change, and typical therapeutic effects is presented in Table 1, offering a structured synthesis of the conceptual framework outlined above. This summary presents the main narrative techniques used in schema therapy, their focus, key mechanisms of change, and typical therapeutic effects. In addition, Table 1 includes a "Resource-oriented applications" column to indicate how the same techniques can be applied with a resource focus - this complementary perspective is elaborated in Section 4.8.

Core Mechanisms of Narrative Change in Schema Therapy

Across the narrative-oriented techniques described in this paper, a coherent set of core mechanisms of therapeutic change can be identified. Although individual methods differ in form, they converge at the level of process, targeting how autobiographical meaning is constructed, revised, and integrated into identity. Across cases, we observed a recurring sequence: (1) activation of emotionally salient autobiographical material, often in fragmented or pre-narrative form; (2) a shift in narrative position from the child-in-experience to an adult author capable of reflection and agency; (3) the emergence of corrective internal voices corresponding to the Healthy Adult and Kind Parent modes; and (4) reconsolidation of meaning, whereby these updated narratives are integrated into a more coherent autobiographical story and current identity.

The process typically begins with the activation of emotionally salient autobiographical material, which is often encoded in a fragmented, sensory, or pre-narrative form. Such memories are closely linked to early maladaptive schemas and are readily reactivated in present situations. Narrative and experiential techniques deliberately bring these memory traces into awareness while maintaining a structured and emotionally safe therapeutic frame.

A critical turning point involves a shift in narrative position. Patients move from being immersed in the perspective of the vulnerable child within the original scene to adopting the stance of an adult author capable

Tab. 1. Narrative techniques in schema therapy: focus, mechanisms and therapeutic effect

Narrative technique	Primary focus	Essential mechanisms of change	Typical therapeutic effect	Resource-oriented applications
Imagery rescripting (ImR)	Traumatic childhood memories	Reconsolidation of emotional memory, corrective emotional experience, change of meaning	Weakening shame and fear, strengthening the feeling of protection and security	Helpful figure from the past.
Chairwork	Internal conflicts between modes	Externalization of inner voices, development of inner dialogue	Strengthening the Healthy Adult, Weakening the Punitive Critic	Healthy Adult and Kind Parent genealogy, embodied rehearsal.
Therapeutic letters	Relationships to significant others and introjects	Symbolic expression of emotions, narrative re-framing of relationships	Releasing repressed emotions, validating needs, self-compassion	Letter from the other side (Healthy Adult and Kind Parent)
River of Life	Life story in a temporal context	Integration of fragmented memories, sharing and validation	Strengthening identity, hope, and story continuity	Tributaries, turning points, witnesses, episodes of competence and lovability.
Inner House	Inner world, personality structure	Symbolic representation of moods and emotional states	Better orientation in the interior, feeling of control and safety	Caring figures in the house; spaces for rest, joy, connection, safety.

of reflection, agency, and intentional action. This repositioning allows the experience to be re-narrated rather than merely relived. From this new position, patients can introduce alternative meanings, contextual understanding, and unmet needs into the story.

Within this re-authored narrative space, a corrective internal voice emerges, functionally corresponding to the Healthy Adult or Kind Parent mode. This voice provides validation, protection, and clear boundaries, directly counteracting punitive or neglectful introjects that previously dominated the narrative. Importantly, the corrective voice does not negate the original experience but transforms its meaning by embedding it within a relationally and emotionally supportive framework.

At the level of memory processing, this transformation can be understood as the reconsolidation of emotional memory traces. The original memory is reactivated and subsequently re-encoded with new affective and semantic information, allowing it to become part of a more coherent and adaptive autobiographical narrative. As a result, previously fragmented or problem-saturated episodes are integrated into a broader life story that tolerates complexity, ambivalence, and continuity.

Finally, narrative change extends beyond the therapeutic setting into the patient's current identity and interpersonal functioning. Patients report greater self-coherence, improved emotional regulation, and increased flexibility in responding to present-day challenges. Rather than being governed by rigid, schema-driven stories, they gain access to a narrative in which agency, compassion, and relational reciprocity are possible.

Taken together, these mechanisms illustrate how narrative processes in schema therapy operate as a central pathway to identity-level change. Symptom reduction emerges as a consequence of a deeper transformation in how patients understand themselves, their past, and their place in relationships—highlighting narrative reconstruction as a core therapeutic mechanism rather than a mere adjunct to cognitive or behavioral change.

While these mechanisms capture core repair-focused processes, clinical narrative work in schema therapy does not occur exclusively through revising deficit-based narratives. In the following section, we outline a complementary resource trajectory and propose practical strategies for balancing both trajectories in individual and group contexts.

Balancing corrective and resource-based narrative work

Clinical narrative work in schema therapy can be conceptualized as unfolding along two complementary trajectories: a corrective or repair trajectory and a resource trajectory. Consistent with the theory-building aim and schema therapy's emphasis on model-based case conceptualization (Arntz & Jacob 2013; Young *et al.* 2003), this distinction is presented as a mechanism-oriented clinical heuristic rather than two mutually exclusive or empirically separable pathways. It reflects patterns observed across the cases in this paper, in which sessions focusing on repairing deficit- and trauma-centred narratives were most stable when complemented by systematic activation and consolidation of resource memories, adaptive self-stories, and positive schema evidence.

In repair-focused work, the therapist and patient revisit narrative "nodes" organized around unmet needs, shame, threat, abandonment, or other EMS congruent meanings. Clinically, this trajectory often "removes" a toxic core meaning (e.g., defectiveness, danger, unworthiness) or introduces a fundamentally different, healing perspective that reorganizes the patient's relationship to the original memory and its identity implications. The core repair-focused sequence of narrative change has been outlined in Section 4.7; here we introduce a complementary resource trajectory and propose practical strategies for balancing both trajectories.

Narrative change in schema therapy can be advanced by systematically activating, elaborating, and consolidating adaptive self-stories and positive schema evidence. In this trajectory, therapeutic work begins with the activation of resource memories (e.g., moments of protection, belonging, competence, care, boundary-setting, moral courage) or with structured collection of counter-evidence to early maladaptive schemas. The goal is not denial of adversity, but increased access to autobiographical material that supports more adaptive meanings and strengthens healthy modes. This orientation aligns with growing empirical interest in positive schemas and their assessment and clinical relevance (Louis *et al.* 2018).

Resource-focused work aligns with autobiographical memory findings showing that positive memory specificity is associated with lower depressive symptoms indirectly via fewer negative self-cognitions in response to negative life events across one year. Supporting a clinical rationale for strengthening access to concrete resource memories in adaptive narrative work (Askelund *et al.* 2019).

Longitudinal narrative identity findings suggest that recounting challenging experiences with more fulfilled motivational themes (agency and communion) is associated with better mental health across time (lower depression and higher well-being), even when controlling for dispositional traits (e.g., neuroticism, extraversion), highlighting the relevance of strengthening adaptive "inner stories" in therapy (Lind *et al.* 2024).

Balancing the two mentioned trajectories will help to avoid "therapeutic narrative narrowing." A therapy process that repeatedly privileges deficit- or trauma-cantered narratives, even when rescripting is helpful, may risk producing an overly narrow life story in which suffering becomes disproportionately central to identity.

Also, a clinically important implication of narrative work is that therapy may temporarily destabilize a previously coherent "good childhood" narrative. As patients adopt a more adult, reflective narrative position, previously excluded meanings (e.g., neglect, unmet needs, fear, shame) may enter awareness and create ambivalence or cognitive dissonance: "If I acknowledge what was painful, can I still hold what was good?". In schema therapy terms, this phase may reflect a shift from protective idealization and detachment toward fuller access to the Vulnerable Child mode, with the risk that the life story becomes briefly narrowed around deficit- and trauma-saturated meanings. Balanced narrative work therefore aims not to replace positive narratives with negative ones, but to restore proportion, coherence, and agency by integrating both resource and repair trajectories, strengthening the Healthy Adult's capacity to hold "both/and" truths and to retrieve resource episodes without reverting to denial.

Clinical strategies to strengthen the resource trajectory within schema therapy.

1. Genealogy of adaptive modes (Healthy Adult / Kind parent functions).

Therapists can explicitly explore how adaptive modes developed over time: who modelled care, protection, fairness, competence, or boundaries; which autobiographical scenes contain early evidence of agency; and what values organize the Healthy Adult and Kind Parent stance. Giving these modes sufficient space is consistent with mode-based case conceptualization (Edwards 2022) and the broader Schema Therapy literature emphasizing adaptive modes as central treatment targets alongside reducing maladaptive modes (Young *et al.* 2003; Arntz & Jacob 2013).

2. Visualizing and Embodying the Healthy Adult.

To strengthen the resource trajectory, the Healthy Adult is first made concrete and retrievable rather than abstract. Following a protocol described by van der Wijngaart, the therapist briefly models a Healthy Adult state by self-disclosing a personal memory of handling difficulty in a healthy way, explicitly naming its emotional, cognitive, behavioural, and embodied markers (e.g., calm confidence, grounded attention, upright posture/voice) (van der Wijngaart 2015). The patient then identifies their own memory of acting from a healthier stance (even if rare) and develops personalized "gateway cues" (posture, gaze, voice, felt sense) plus a vivid image of "me-as-Healthy-Adult." This embodied access route is consistent with schema therapy clinical approach that conceptualizes modes as involving somatic patterns and supports using the body to enhance mode awareness and transformation (Briedis & Startup 2020). Homework is daily short rehearsal of this visualization in non-challenging contexts, so that under stress the patient can access the same stance more easily. This work is complemented by a simple "3 steps of the Healthy Adult" script: (1) acknowledge the Vulnerable Child distress, (2) offer hope/perspective, (3) deal with reality through appropriate action and mode management—practised in this order to avoid premature problem-solving without validation (van der Wijngaart 2015).

3. Structured resource-based narrative "anchors" (e.g., three-year evidence mapping).

A practical method is to map episodic evidence for adaptive meanings at regular intervals (e.g., every ~3 years): brief scenes showing care received, competence, belonging, effective coping, protection, or courageous boundary setting. This resembles structured CBT practices that build alternative belief systems through cumulative evidence (e.g., positive data logging) and can be integrated into schema work as "positive schema evidence."

Autobiographical memory research supports the general principle that improving access to specific episodic memories (including positive specificity) is clinically relevant to affective vulnerability and recovery processes.

Practical balancing guideline. In individual therapy, clinicians may intentionally pair corrective sessions with explicit resource work to prevent overconcentration on deficit narratives. In groups, the balance can be amplified by using other members as resource witnesses, not only validating pain, but also noticing strengths, agency, and moments of care, thereby supporting internalization of compassionate and protective voices. Table 2.

ADDITIONAL CASE ILLUSTRATIONS

The following selected case illustration provides a focused demonstration of how narrative mechanisms operate in schema therapy at the level of autobiographical meaning and identity reconstruction. Additional clinical material is used to highlight convergent processes across techniques.

A Patient with Borderline Personality Disorder – Imagery Rescripting (ImR) of a Childhood Trauma

Lucie, a 27-year-old woman, was admitted to a specialized psychotherapy program for patients with borderline personality disorder. Her clinical presentation was characterized by recurrent unstable intimate relationships, intense fear of abandonment, chronic inner emptiness, and episodes of self-harming behavior. In therapy, Lucie repeatedly stated that she "does not know who she really is" and described herself through a narrative dominated by shame, self-blame, and a pervasive sense of defectiveness.

Her developmental history revealed a chronically adverse relational environment. The father was authoritarian, emotionally unpredictable, and punitive, frequently responding to minor mistakes with shouting, ridicule, and humiliation. The mother was emotionally distant, passive, and unable to provide protection or emotional attunement. Lucie grew up in a family context where acceptance was conditional upon obedience and performance.

Table 2. Core mechanisms of narrative change by schema therapy technique

Narrative technique	Dominant level of activation	Mechanism step emphasized in the sequence (activation → position shift → corrective voice → reconsolidation → identity change)	Typical narrative transformations	Typical identity-level outcomes
Imagery rescripting (ImR)	Autobiographical imagery and emotional memory	Strong emphasis on activation of emotionally salient childhood scenes and subsequent shift from child-in-experience to adult/ protective position; introduction of corrective internal and external voices (Healthy Adult, Kind Parent) during rescripting; consolidation of updated meanings in key "foundational scenes"	Fragmented or shame-saturated scenes are restructured into narratives that include protection, validation, and fulfilled needs; traumatic episodes become integrated as past events rather than ongoing threats	Strengthening of Healthy Adult and Kind Parent modes; weakening of punitive introjects; increased self-compassion; greater continuity between past and present self; reduced automatic schema activation in current situations
Chairwork	Dialogical, embodied interaction between modes	Strong emphasis on position shifts between internal voices (e.g., Vulnerable Child, Punitive Critic, Detached Protector, Healthy Adult, Kind Parent); explicit articulation and confrontation of maladaptive voices; development and rehearsal of corrective internal dialogue	Rigid, one-voiced stories (dominated by the critic or protector) become multi-voiced narratives in which needs, limits, and contextual understanding can be expressed; problem-saturated plots are deconstructed into distinct positions	Increased access to Healthy Adult and Kind Parent positions in daily life; reduced dominance of punitive and avoidant modes; improved emotion regulation and capacity for reflective self-positioning in relationships
Therapeutic letters	Symbolic verbal expression and relational meaning	Emphasis on explicit articulation of narrative position (e.g., "uncensored" letters from the child/ adult self) and on constructing alternative perspectives (e.g., "letter from the other side" from Healthy Adult or Kind Parent); supports both activation and corrective voice steps, with written text anchoring reconsolidated meanings	Previously implicit or inhibited stories about significant others and parental introjects become explicit, contextualized narratives; boundaries between past relationships and present self are clarified; new internal dialogues emerge	Expanded repertoire of internal voices beyond the punitive narrator; increased validation of needs and self-worth; clearer differentiation between historical and current relationships; strengthened narrative agency
River of Life	Visual and temporal organization of the life story	Emphasis on activation and integration of multiple life episodes within a continuous temporal framework; shifts in narrative position occur through joint mapping and group feedback; corrective and validating voices arise in the group context and support reconsolidation of the overarching life story	Fragmented, discontinuous, or problem-focused life stories are reorganized into more coherent narratives that include turning points, supportive relationships, and episodes of competence and joy; individual stories are situated within a shared group narrative	Strengthened sense of self-continuity and belonging; increased hope and future orientation; internalization of group-based Healthy Adult and Kind Parent voices; reduced identification with a purely trauma- or failure-defined identity
Inner House	Symbolic spatial representation of inner world and modes	Emphasis on making modes and narrative positions tangible (rooms, figures, boundaries); facilitates position shifts (e.g., relocating or limiting access of punitive figures, creating protected spaces for the child) and supports ongoing corrective dialogues within a structured symbolic environment; aids in consolidating new internal organization	Diffuse or chaotic inner experience becomes represented as a more organized "inner architecture" in which different parts have defined places, roles, and access; new narratives about safety, control, and connection are symbolically enacted	Greater sense of internal orientation, control, and safety; increased availability of nurturing and regulating positions; reduced dominance of intrusive punitive or avoidant spaces; more flexible, coherent narrative identity grounded in an organized inner world

Legend: Core mechanisms of narrative change by schema therapy technique. This table summarizes how each of the main narrative techniques described in this article (imagery rescripting, chairwork, therapeutic letters, River of Life, and Inner House) engages the core sequence of narrative change identified in the case material. For each technique, it specifies the dominant level of activation (e.g., autobiographical imagery, dialogical interaction, symbolic representation, temporal life-story structure), highlights which steps of the mechanism sequence are most strongly emphasized (activation of emotionally salient autobiographical material, shift in narrative position, emergence of corrective internal voices, reconsolidation of meaning, and identity-level change), and describes typical narrative transformations and identity-level outcomes observed in patients with personality disorders and complex trauma-related conditions.

Schema-therapeutic formulation identified the Defectiveness/Shame and Emotional Deprivation schemas as central, with frequent activation of the Vulnerable Child, Punitive Critic, and Detached Protector modes.

Target Memory and Narrative Fixation

During therapy, one childhood memory repeatedly emerged as emotionally dominant. Lucie described an incident at the age of seven when she brought home a poor school grade. Her father publicly ridiculed her in front of her siblings, raised his voice, and questioned her intelligence and worth. Lucie recalled standing alone in the middle of the kitchen, feeling exposed and overwhelmed, with a strong bodily urge to "disappear." This moment became crystallized in her internal narrative as a defining truth: "I am useless. I will never be good enough."

ImR Process

In the initial phase of ImR, Lucie was guided to re-enter the scene from the perspective of her child self. Her voice became quiet and hesitant, her posture contracted, and tears appeared. She reported intense shame, fear, and emotional loneliness, repeatedly expressing statements such as: "I just want someone to love me," and "I made a mistake, but that doesn't mean I'm bad." The Vulnerable Child mode was fully activated, accompanied by the internalized Punitive Critic voice reproducing the father's criticism.

In the subsequent phase, Lucie was invited to enter the scene as her current adult self. She imagined walking into the kitchen, positioning herself physically between her father and the child, and speaking firmly: "You will not humiliate her. She is a child and she has the right to make mistakes." Lucie described a marked shift in bodily experience, reporting a sense of strength and grounding. She then imagined taking the child by the hand, leading her out of the room, and saying: "You are not useless. You are my child, and I will not leave you."

Spontaneously, Lucie extended the scene further. She imagined bringing her child self to a quiet, safe place, sitting together, holding her hand, and repeatedly assuring her of safety and acceptance. After completing the imagery, Lucie reported a clear somatic shift—release of tension in her chest, warmth in her body, and slowed breathing. She stated: "For the first time in my life, I felt that someone was on my side."

Post-intervention Development

In the weeks following the intervention, Lucie reported noticeable changes in her responses to interpersonal stress. In situations involving criticism or perceived rejection, she was increasingly able to recognize the activation of old narrative patterns. Although the self-critical voice did not disappear entirely, it became less dominant. Instead of resorting to self-harm, Lucie more frequently used emotion regulation strategies and intentionally recalled the image of herself protecting her child self. Gradually, a new narrative motif emerged—the possibility of standing up for herself and acknowledging her own needs.

Brief Analytical Examination of the Therapeutic Process

From an analytical perspective, ImR represented a pivotal moment in the narrative reorganization of Lucie's identity. The original memory functioned as a core narrative node organizing her self-concept around shame, defectiveness, and emotional abandonment. This rigid story was repeatedly reactivated in adult relationships, reinforcing maladaptive schemas and dysregulated coping.

ImR enabled not only the emotional reactivation of the traumatic memory, but also a fundamental transformation of its meaning. The entry of the adult Lucie into the scene marked a decisive shift in narrative position—from a helpless child trapped inside the experience to an adult author capable of protection, agency, and moral authority. This intervention strengthened the Healthy Adult mode, weakened the dominance of the Punitive Critic, and introduced a corrective internal voice grounded in validation and care. At the level of narrative identity, the defining story "I am useless" was gradually replaced by a more adaptive narrative: "I was a child who needed protection." This reframing allowed the traumatic experience to be integrated into a broader, more compassionate autobiographical narrative. The corrective emotional experience became an internalized resource that Lucie could access in present-day situations, supporting behavioral change and emotional regulation.

This case is consistent with empirical findings suggesting that ImR modifies emotional memory traces and may facilitate their reconsolidation within autobiographical memory, thereby potentially reducing symptom severity and supporting adaptive functioning (Arntz 2012; Recher *et al.* 2024).

Using a Therapeutic Letter to Reframe the Relationship to the Parental Introject

The patient Eva, a 33-year-old woman, was included in a group psychotherapy program for individuals with recurrent depressive episodes. The clinical picture was dominated by long-term feelings of worthlessness, significant self-criticism, and a tendency to adapt to the expectations of others at the expense of her own needs. Eva repeatedly reported that she "lives as if someone is constantly evaluating her" and that she perceives any failure as evidence of her personal inadequacy.

A significant role in her medical history was played by her relationship with her mother, who was strict in regard to education, emotionally cold, and critical. Eva grew up in an environment where praise was rare and love was conditional on performance. In therapy, she often reported a strong inner voice that accompanied her in everyday situations and that sounded "like my mom." This voice repeated statements such as: "You messed up again," "No one will like you," and "You should try harder." Schema-therapeutic conceptualization indicated a significantly active punitive parental mode, maintaining the Defectiveness/Shame schema and contributing to depressive symptoms.

Working with a Therapeutic Letter

As part of the therapy, a procedure was proposed using a therapeutic letter addressed to her mother. The goal was not to achieve change in the real relationship, but to enable Eva to externalize long-term suppressed emotions and separate her authentic voice from the internalized critical introject. Eva was given the task of writing an uncensored letter in which she could freely had not been able to express everything that she could not express in childhood and adolescence.

After a week, Eva brought the letter, which she read aloud to the group. Her voice trembled at times and she repeatedly stopped to catch her breath. The letter read:

"Mom, I've tried my best to please you all my life, but I've never been good enough. Your eyes have always judged me. I've never heard you say you loved me. It hurts and I don't want your voice to guide my life anymore. I want to live my own life."

Reading the letter was accompanied by a strong emotional reaction. Eva cried, but at the same time she described a sense of relief, as if "a heavy burden had been lifted from me." Other group members responded with support and shared their own experiences with critical parental voices. This group validation strengthened Eva's belief that her feelings were understandable and legitimate.

In the next phase, the therapist suggested writing a so-called "letter from the other side" – a letter that Eva needed to hear from her mother so that her unmet needs could be symbolically acknowledged. Eva hesitated at first, stating that "it sounds unnatural," but eventually she embarked on the task. The text of the letter read:

"I am proud of you. I am sorry that I never told you how much I loved you. You were sensitive and hardworking. You deserve love and support."

While reading this letter, Eva described ambivalent emotions – sadness that she had never heard these words, but at the same time a deep sense of relief and peace. She stated: "This was the first time that the voice did not sound like a reproach."

Development after the Intervention

In the following sessions, Eva reported that when the inner critic was activated, she could recall the content of the "letter from the other side". Although the critical voice did not disappear completely, it lost its strength and authority. Eva began to distinguish more between the voice of the Punitive Critic and her own view of herself. A new motif appeared in her self-narration – the right to her own value, independent of the performance and others approval.

Brief Analytical Examination of the Therapeutic Process

From an analytical perspective, working with therapeutic letters enabled a fundamental narrative reframing of the relationship with the parental introject. Originally, Eva's inner story was organized around the voice of the critical mother, which functioned as the dominant narrator of her identity. This voice maintained a rigid narrative of "I am inadequate," which was automatically activated in situations of relationship failure or threat.

The uncensored letter enabled the externalization of this introject and a clear delineation of the boundary between the past relationship and the current self. Eva for the first time placed herself in the position of an active author of her story, who could name and question the critical voice. The "Letter from the Other Side" then created an alternative narrative position – a voice of validation, support, and acceptance, which corresponds to the function of the Kind Parent in schema therapy.

From a narrative identity perspective, the repertoire of inner voices expanded. Eva was no longer confined to the Punitive Critic mode, but gained access to a new, more compassionate narrative about herself. The group context played an important role in legitimizing this change, as the reactions of other patients provided a corrective relational experience and enhanced the internalization of supportive voices.

This process is consistent with research findings showing that therapeutic letters facilitate emotional processing, weaken the influence of dysfunctional introjects, and promote the reconstruction of personal narrative, especially within group schema therapy (Prasko *et al.* 2024a).

Group Work Using the River of Life Method – Sharing and Transcribing a Collective Story

A heterogeneous group of patients diagnosed with borderline personality disorder and chronic depressive disorder was included in the schema therapy group program. The group worked in a closed format and was led by two therapists. In the middle phase of the therapy, the River of Life method was used as a tool to connect individual life stories with group dynamics and to support the integration of fragmented experiences in a safe relational context.

Each group member was invited to depict his or her life story as the flow of a river – from the source in childhood to the present. The patients drew key events, obstacles, burdens and resources into the river, in the form of symbols, images and short descriptions. The emphasis was not on chronological accuracy, but on the subjective meaning of individual moments.

Group Process and Sharing

A patient named Martina, a 29-years-old patient, who was in long-term treatment for borderline personality disorder with significant depressive features, drew a large boulder in her river representing her parents' divorce in early childhood. She described feeling intense fear, insecurity, and a strong sense of responsibility for her younger sister at that time. She stated, "I felt like I had to take care of others, otherwise everything would fall apart." She said this motif was repeated in adult relationships, where she often took on a caring role at the expense of her own needs.

When she shared her river, the other group members paid close attention. One of the patients, Tomáš, 34, who was in treatment for chronic depression, noticed several smaller tributaries that Martina had drawn in the river, but Martina herself did not attach importance to them. These tributaries symbolized the support of her elementary school teacher and a friend from adolescence. Tomáš told Martina, "I see that your river also had sources of support, even though you may not have seen them at the time." This comment shook Martina considerably and she began to cry. She stated that until then she had perceived her childhood exclusively as a period of loss and loneliness.

In the next round of sharing, Martina was invited to reflect on what she had missed at that time. One of the patients in the group, who was supported by the therapist in the role of the Kind Parent, turned to Martina and said: "Martinka, you shouldn't have been alone. You were a child and you deserved to be hugged and protected." Martina burst into tears and, after a while, replied, "That's the first time I've heard such words. I wish someone had said them to me back then."

This moment was very powerful in the group and the other members reflected that they recognized themselves in Martina's

Table 3. Typical narrative dysfunctions in patients and their therapeutic transformation

Narrative dysfunction	Typical presentation in therapy	Narrative interventions used	The resulting change in narrative
Fragmented story	Disjointed memories, amnesia, memory gaps, dissociation	Imagery Rescripting, River of Life	A more coherent autobiographical narrative
The dominance of the critical voice	Self-criticism, shame, rigid moral judgments	Chairwork, therapeutic letters	Strengthening the voice of compassion and protection
Problem-saturated story	A story focused only on failure and loss	River of Life, group sharing	Incorporating resources, hope, and alternatives
Limited access of a Healthy Adult	Helplessness, impulsiveness, dependence on others	Imagery Rescripting, Inner House	Developing self-regulation and autonomy
Disrupted narrative identity	Unstable self-concept, frequent changes in perspectives	Integrated multimethod work	A more flexible, stable identity

story. The sharing gradually grew from individual work into a collective narrative, in which the motifs of abandonment, premature responsibility and unfulfilled needs, as well as the gradual search for resources and hope, were repeated.

Narrative Change and Subsequent Development

During the final reflection of the exercise, Martina stated that her view of her own life story had changed. She described, that for the first time, she could perceive her past not only as a "struggle for survival", but also as a journey on which people and moments of support appeared that had previously remained in the background. This shift was also evident in subsequent sessions, when Martina reflected on her needs more often and was able to allow herself to ask for help.

Brief Analytical Examination of the Therapeutic Process

From an analytical perspective, the River of Life method enabled the integration of the individual narrative into a broader relational and temporal framework. Martina's original story was organized around the rigid motif of "I must be strong", which corresponded to the long-term activation of the Self-Sacrifice and Emotional Deprivation schemas. This narrative was maintained not only on an intrapsychic level, but also in her current relationships.

Group sharing enabled this dominant story to be questioned from the perspective of others. The comments of other group members functioned as externalized voices of the Healthy Adult and the Kind Parent, helping Martina expand her perspective on her own past. The moment when the group acknowledged her unmet childhood needs and explicitly named them was crucial, thereby weakening the internalized belief that she "has no right to her needs."

Narratively, Martina's life story shifted from a one-sided, problem-laden narrative to a more flexible narrative that included both painful and positive experiences and resources, relationships, and the possibility of change. The group context played a key role in the corrective emotional experience and supported the internalization of supportive voices.

This clinical process is consistent with empirical studies showing that the River of Life method increases group cohesion, promotes the integration of traumatic memories, and strengthens healthy modes, especially the Healthy Adult and the Kind Parent (Farrell & Shaw 2012; Prasko *et al.* 2024b).

DISCUSSION

This article proposes that narrative processes represent one of the key mechanisms of therapeutic change within schema therapy. Their significance goes beyond the modification of individual maladaptive schemas or coping strategies and is directed towards a deeper reconstruction of identity. Working with narrative allows patients to reorganize the way they understand their past, structure their present experiences, and anticipate the future. Schema therapy is thus profiled as an approach that integrates the narrative dimension directly into the core of the therapeutic process. Typical narrative dysfunctions described in the theoretical part of the article and their therapeutic transformation, illustrated across case studies, are summarized in Table 3.

Across the case studies, a common mechanism of change emerges repeatedly, consisting of the transformation of a rigid, problematically saturated life story into a more flexible and compassionate narrative. In the case study of a patient with borderline personality disorder, imaginative rescripting enabled the interruption of the original scenario, in which the voice of the punishing parent and the position of the ashamed, helpless child dominated. The creation of a new narrative position, represented by the adult part of the personality capable of protection and validation, led to the rewriting of the meaning of the traumatic experience and the weakening of the Defectiveness/Defectiveness schema. This process corresponds to the concept of corrective emotional experience, considered one of the basic factors of change in schema therapy (Arntz 2012; Edwards 2022). An analogous mechanism can also be observed in the case study focused on therapeutic letters. Here, narrative work enabled the externalization of dysfunctional parental introjects and the creation of an alternative inner dialogue. The uncensored letter clearly defined the boundary between the

past relationship and the present self, while the "letter from the other side" symbolically filled the unmet needs for acceptance and recognition. In terms of narrative identity, the repertoire of internal voices expanded: the patient was no longer dependent on a single, punishing narrator, but gained access to a voice of validation and compassion. This shift contributes to the weakening of rigid self-representations typical of depressive and personality disorders (Salvatore *et al.* 2004; Soroko 2015).

The group context has a specific advantage, especially evident in the case study using the River of Life method. Group sharing allows the individual narrative to become part of a broader collective story, in which painful experiences are not only heard, but also validated and reinterpreted through the perspective of others. The reactions of group members here functioned as externalized voices of the Healthy Adult and the Kind Parent, which the patient gradually internalizes. This process supports not only the change of individual narrative, but also group cohesion and a sense of belonging, which are considered key therapeutic factors in the treatment of borderline personality disorder (Farrell & Shaw 2012).

From a theoretical perspective, narrative work in schema therapy allows for the integration of cognitive, emotional, and physical levels of experience. Fragmented traumatic memories, often stored outside the usual autobiographical narrative, can be gradually integrated into a coherent story through imaginative and symbolic techniques. This may reduce the risk that trauma will manifest itself predominantly in the form of intrusive images, dissociative states, or somatic symptoms, as is typical for complex post-traumatic states (Chu *et al.* 1999). The continuity of the narrative is a basic prerequisite for identity stability, which in patients with personality disorders is often disrupted by fragmentation or rigidity of the life story.

At the same time, it is necessary to reflect on the limits of narrative interventions. Working with traumatic material can lead to overload or retraumatization, especially if a sense of safety is not sufficiently ensured and if the therapist does not respect the individual pace of the patient (Arntz & Jacob 2013). In patients with significant dissociation, too rapid narrative activation can lead to disorganization of experience and worsening of symptoms. For this reason, it is crucial to systematically combine narrative techniques with stabilization procedures such as mindfulness, somatic (body related) work, and the use of group support. We assume, that the integration of narrative techniques with other therapeutic approaches further increases their effectiveness. Within cognitive-behavioral therapy, narrative techniques allow for a deeper change in implicit beliefs that often remain inaccessible to purely rational restructuring (Beck *et al.* 1979; Young *et al.* 2003). Mindfulness supports the ability to remain in the present moment when working with painful memories and reduces the risk of dissociation (Segal *et al.* 2018), while positive psychology emphasizes resources, values, and meaning that can be integrated into the emerging life story (Seligman 2011).

Another clinical risk is narrative destabilization and ambivalence, when therapy disrupts a previously coherent "good childhood story." As excluded meanings enter awareness, patients may experience cognitive dissonance and a temporary narrowing of the life story around deficit and trauma saturated themes. Therapists may therefore need to anticipate and normalize this transitional phase and support integration through careful pacing, stabilization strategies, and self-compassion-based work that strengthens the Healthy Adult's capacity to hold "both-and" truths.

Other research suggests that narrative identity reconstruction may also be supported by memory consolidation processes. A study by Recher *et al.* (2024) shows that targeted memory reactivation during sleep after ImR can enhance the modulation of emotional memory and stabilize therapeutic changes. These findings are consistent with the hypothesis that narrative change in schema therapy may be anchored not only at the psychological but also at the neurobiological level, although this link remains preliminary and requires systematic testing.

CONCLUSION

The narrative approach represents a fundamental framework in schema therapy that allows not only for the understanding of the emergence and maintenance of early maladaptive schemas and modes, but also for their purposeful change through the reconstruction of the personal story. Working with narrative reveals how life experiences are organized into rigid self-representations, and at the same time creates space for their transformation through corrective emotional and relational experiences.

Retelling the life story allows for the symbolic and experiential fulfilment of previously frustrated basic emotional needs and supports the strengthening of the Healthy Adult and the Kind Parent. The result is a more flexible identity, greater self-regulation ability, and more adaptive ways of responding in interpersonal relationships, which has a direct impact on the long-term stability of therapeutic changes.

From the perspective of clinical practice and research, narrative schema therapy offers a promising direction for further development. Future studies should systematically investigate the effectiveness of individual narrative techniques, their optimal combinations in individual and group formats, and their potential links to neurobiological mechanisms of change. The narrative perspective may thus represent an important bridge between psychotherapeutic theory, clinical practice, and contemporary neuroscientific findings.

CONFLICT OF INTEREST STATEMENT

The authors declare that this work was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

Artificial intelligence tools were used to support language editing and stylistic refinement. The authors take full responsibility for the final content, interpretations, and conclusions.

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