REVIEW ARTICLE

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Integrating music and schema therapy for inpatients: A case-based framework

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Abstract

BACKGROUND: Integrating musical elements into schema therapy may enhance emotional access and mode work in psychiatric patients. This study explores the feasibility and potential therapeutic value of structured music-based interventions integrated with the schema mode model.

OBJECTIVE: The aim of this study is to describe and illustrate an integrated therapeutic model combining music therapy and schema therapy within inpatient psychiatric care for patients with personality disorders, mood disorders, and complex trauma.

METHODS: Five clinical case studies of inpatients with various diagnoses (ICD-10) were selected; three are presented in full narrative form, and two are summarized in the comparative case overview. Each case was analysed based on dominant modes, musical strategies applied, and short- and long-term effects. Qualitative data include therapist notes and patients' subjective feedback.

RESULTS: Music interventions allowed emotional expression and modulation, particularly in Vulnerable Child and Angry Child modes. Patients reported enhanced internal safety and self-understanding. Observable behavioral changes included increased autonomous decision-making (Case 1), reduced hypervigilance to auditory stimuli (Case 2), and the capacity to tolerate emotional presence without dissociation (Case 3). Positive changes were observed in mode accessibility and reduction in self-stigma.

CONCLUSION: Integrating musical work into schema therapy shows clinical promise in facilitating corrective emotional experience. Further research using single-case experimental design and controlled designs is recommended.

Introduction

The use of music in the context of psychotherapy for hospitalized patients

Music, as a universal form of nonverbal communication and emotional expression, holds a unique position in the psychotherapeutic context (Pérez-Aguado *et al.* 2023). Its ability to evoke complex affective states, facilitate the release of repressed emotional material, and access autobiographical memories makes it a powerful medium for working with deeper layers of patients' inner experience (Atiwannapat *et al.* 2016). Particularly in psychiatric inpatient settings, where patients frequently struggle with emotional dysregulation, rigid maladaptive behavioral patterns, and impaired relational functioning, music can serve as a therapeutic bridge between inner experience and interpersonal engagement (Beck 1976; Koekkoek *et al.* 2009; Nizamie & Tikka 2014).

Hospitalized patients often present with severe mental disorders, including mood, psychotic, and personality disorders, and may exhibit limited introspective capacity, high levels of anxiety or dissociation, and negative expectations regarding therapeutic relationships. These characteristics pose specific challenges for structured psychotherapeutic approaches focused on cognitive-emotional integration and schema change. Schema therapy (Young *et al.* 2003), which targets deeply rooted patterns of thinking, feeling, and behaving formed in early life, may be particularly demanding in acute or post-acute settings, where patients are overwhelmed or emotionally withdrawn.

In this context, the integration of expressive techniques—especially music therapy—offers an effective means of accessing and modulating patients' experiential world. Music enables engagement with imagination, bodily sensations, nonverbal expression, and affective processing in ways that may bypass verbal defence mechanisms or cognitive over-intellectualization (Aalbers *et al.* 2017; Pérez-Aguado *et al.* 2023). Through rhythm, melody, and improvisation, patients can explore their emotional states, externalize internal conflicts, and experiment with new relational roles in a safe and symbolically mediated space (Geretsegger *et al.* 2017; Koelsch 2015).

From a schema therapy perspective, music may be particularly well suited to working with schema modes, which represent state-dependent patterns of emotion, cognition, and behaviour. Modes such as the Vulnerable Child, Angry Child, or Detached Protector are often activated under conditions of heightened emotional arousal, in which verbal reflection alone may be insufficient. As an affective and embodied medium, music can facilitate access to these modes, support emotional regulation within the therapeutic relationship, and enable experiential change. This quality may be especially relevant in inpatient settings, where patients frequently fluctuate between emotional hyperarousal and withdrawal.

Recent clinical research has shown increasing interest in the integration of music therapy techniques into psychotherapeutic interventions for a wide range of diagnostic groups, including individuals with depressive disorders, psychoses, and personality disorders (Hanson-Abromeit 2015; Jia *et al.* 2020; Hong *et al.* 2025). Within schema therapy, music and also sound interventions can support the activation of emotional modes, facilitate emotional correction through expressive and relational experiences, and help to strengthen the *Healthy Adult Mode*, a central therapeutic goal in schema therapy (Young *et al.* 2003; Fachner *et al.* 2019; Lassner *et al.* 2024).

This article critically explores the clinical potential of combining music therapy with schema therapy in both group and individual formats for hospitalized patients. It presents five case studies — three developed in full narrative detail and two presented in abbreviated clinical form — illustrating how musical techniques can be used to activate, regulate, validate, and transform maladaptive schemas and modes. Emphasis is placed on specific therapeutic strategies, the structure and dynamics of the therapeutic setting, and the observed clinical benefits of this integrative approach. This article addresses a significant gap in the literature by proposing the first structured framework for combining music interventions with schema therapy for inpatient psychiatric populations — one that explicitly maps musical techniques onto schema mode work, supports clinical formulation, and enables hypothesis-driven intervention design.

This article also introduces a novel clinical integration model that explicitly maps musical interventions onto schema therapy mode work in psychiatric inpatients. It provides a structured framework that supports clinical formulation, therapeutic planning, and hypothesis-driven intervention design, offering a unique contribution to the literature on integrative psychotherapy approaches.

Methods

This article presents a narrative synthesis of theoretical perspectives and clinical experience derived from long-term work in a psychiatric inpatient department in the Czech Republic. The department specializes in the treatment of adults with various psychiatric diagnoses, including depressive disorder, bipolar affective disorder, borderline personality disorder, schizoaffective disorder, anxiety disorders, and other comorbid conditions. The clinical program combines cognitive-behavioural therapy (CBT), schema therapy, and expressive therapies—particularly music therapy and art therapy—into an integrative treatment model.

The central focus of this article is the integration of music therapy into schema therapy in both group

and individual formats. The theoretical framework draws on contemporary literature in schema therapy, music therapy, and integrative psychotherapy, with an emphasis on experiential techniques such as imagery rescripting, reparenting, and mode work. Relevant sources were selected purposively, with priority given to peer-reviewed studies, clinical manuals, and conceptual papers that emphasize emotional regulation and corrective emotional experiences.

The clinical material is based on a structured therapeutic program implemented over several years, in which weekly music therapy sessions were systematically integrated with schema therapy interventions. Music therapy was provided twice weekly by a certified music therapist with working knowledge of schema therapy principles, enabling close coordination with individual and group schema therapists. Sessions took place in a dedicated therapeutic space equipped with musical instruments, audio recording tools, and visual art supplies.

Five anonymized case studies were selected. Three (Lenka, Veronika, Iveta) are developed as full narrative case presentations; two (Martina, Adam) are presented with schema development and music therapy narra-

Tab. 1. Musical correlates of schema therapy modes and corresponding intervention strategies

Mode	Emotional characteristics	Musical expression	Type of intervention	Intervention objective
Music-Induced Transference and Countertransference	Projective emotional content, relational dynamics	Spontaneous group improvisation, projective techniques with instruments and soundscapes	Therapist-guided reflection and containment	Exploration and understanding of relational patterns
Vulnerable Child	Sadness, abandonment, fear	Melancholic melody, chaotic rhythm or silence	Musical dialogue with the Kind Parent	Contact, validation of emotions
Angry Child	Rage, frustration, unmet needs	Dissonant harmonies, fast tempo, sudden dynamic shifts, chaos	Expressive improvisation, rhythm-based play	Safe expression and regulation of anger
Detached Protector	Emotional numbing, withdrawal, avoidance	Monotonous texture, minimal dynamics, repetitive patterns, silence	Gradual musical activation, joining rhythms	Encouraging emotional engagement
Angry Protector	Defensive anger, hypervigilance, mistrust	Loud dynamics, defensive phrasing, repetitive motifs	Rhythmic grounding, reflective dialogue	Building trust and transforming protective stance
Critical Mode	Shame, self-criticism	Sharp, percussive tones, irregular rhythm	Externalization and confrontation	Reducing the impact of criticism
Overcompensator	Dominance, control, perfectionism	Strong rhythms, emphatic articulation	Intentional work with musical „mistake“	Reduction of perfectionism and control
Self-soother	Passive avoidance, superficial relief	Hypnotic loops, smooth textures, detached harmonies	Contrastive musical confrontation	Increasing awareness and redirecting coping patterns
Happy Child	Joy, spontaneity, connection	Playful melodies, syncopated rhythms, major keys	Playful musical improvisation and rich experiments	Strengthening play, connection, and freedom
Kind Parent	Care, empathy, support	Lullaby, melodic harmony	Reparenting with music	Strengthening safety and care
Healthy Adult	Integration, stability, compassion	Balanced structure, cohesive form, harmonic resolution	Integrative musical reflection	Support for integration and mode leadership

Each row represents one schema mode as defined within the Young et al. (2003) mode model. Emotional characteristics describe the affective and relational features typical of that mode in psychiatric inpatient presentations. Musical expression lists the spontaneous or elicited acoustic qualities — including rhythm, dynamics, timbre, and texture — associated with that mode during improvisation or receptive music tasks. Type of intervention specifies the music therapy technique recommended when that mode is dominant. Intervention objective states the schema-therapeutic goal the musical technique is designed to serve (e.g., emotional contact, externalization, regulation, reparenting, or integration). The top row (Music-Induced Transference and Countertransference) is not a schema mode per se but represents a relational dynamic that may emerge across modes during group and individual music therapy; it is included because it requires distinct therapist management. All interventions are designed for delivery by a music therapist with familiarity with schema therapy principles within a structured inpatient setting.

tives and summarized in Table 2. Antonín, referenced in Table 2, represents a brief comparative illustration. The cases were chosen to reflect a range of diagnoses, schema modes, and therapeutic trajectories. All patients provided written informed consent for the anonymized use of their clinical material for educational and research purposes, in accordance with institutional ethical guidelines and the Declaration of Helsinki. The study was conducted under the ethical oversight of [The joint ethics committee of the University Hospital and the Faculty of Medicine, Palacky University in Olomouc, approved the study on March 8, 2021], approval reference [reference no. 45/21]. Given the psychiatric inpatient context, capacity to consent was confirmed by the treating clinician prior to enrolment.

Clinical data were collected through therapist session notes, audio recordings of musical improvisations, reflective therapist logs, and team supervision discussions. In some cases, post-session patient reflections were also gathered. The analysis followed a narrative clinical approach, integrating both descriptive and interpretive elements to illuminate therapeutic mechanisms and turning points within the therapy. Although this article does not present quantitative outcome measures, it aims to offer structured clinical insights into the integration of music therapy and schema therapy and their synergistic effects on emotional processing, mode transformation, and therapeutic alliance.

Theoretical frameworks and benefits of integration – schema therapy and the therapeutic use of music

Schema therapy, as developed by Young *et al.*. is based on a synthesis of cognitive-behavioural therapy, transference theory, and attachment theory, emphasizing the identification and change of maladaptive schemas that arose in childhood based on unmet emotional needs (Young *et al.* 2003; Erkkilä *et al.* 2011). In therapeutic work with hospitalized patients, we often encounter rigid patterns that are activated by stressful interpersonal situations and manifest in schema modes, such as the Vulnerable Child, the Critical mode or the Detached Protector. When coping modes dominate, emotional systems are suppressed through increased prefrontal inhibition of limbic processing, a pattern observed in emotional avoidance, dissociation, and overcontrol (Lanius *et al.* 2010). Working with these modes requires emotional involvement, validation of experiences, and the gradual development of a Healthy Adult perspective (Padesky 1994).

Music can play an important role in this process. Its unique ability to address emotions, bodily experiences, and unconscious content makes music therapy a suitable tool for working with schemas that are otherwise difficult to access verbally (Aigen 2014). The musical environment allows patients to establish contact with their inner world, often before they are able to reflect on it verbally. Emotionally charged musical moments can activate schemas in a safe context and open up space for corrective experience through interaction with the therapist and the group. In clinical practice, integrating musical interventions within a schema therapeutic framework has been observed to increase access to emotional experience and to support authentic self-expression in therapy. Music can be used to establish contact with the vulnerable part of the patient's self, to express anger or sadness, and can also support the identification of internal resources and personal strengths (Chong *et al.* 2024).

Neuroscientific studies show that music activates limbic structures involved in emotional reactivity, while also increasing functional connectivity with medial prefrontal and anterior cingulate regions involved in self-regulation and attachment (Koelsch 2014; Koelsch 2015; Blood & Zatorre 2001). This neurobiological pattern closely parallels the therapeutic aim of accessing the Vulnerable Child mode while sustaining Healthy Adult regulation — a central goal of schema therapy.

Through rhythm, melody, and harmonic expectancy, music accesses affective memory networks which are often inaccessible to verbal processing alone (Janata 2009; Koelsch 2014). At the same time, musical structure provides predictability and safety, allowing emotional activation to occur without overwhelming the system. In schema therapy terms, music facilitates a shift from coping mode to Vulnerable Child mode activation while being supported by the Healthy Adult mode.

Different music therapy techniques, like improvisation, voice work, song selection or rhythmic interaction, allow different approaches to individual modes (Aigen 2014). For example, rhythm-based interventions may facilitate expression of the Angry Child mode, while a calmer musical structures melody can support soothing the Critic Mode or activating the Healthy Adult or Kind Parent. At the same time, the integration of music therapy supports work with transference and countertransference, which are very important in the treatment of hospitalized patients. Musical interactions can reveal unconscious relational expectations and contribute to the safe processing of traumatic experiences (see Table 1 for a full mode-by-mode overview). In addition, current research shows a positive impact of music therapy on symptoms of depression, post-traumatic stress disorder, psychotic disorders and anxiety states, which supports its inclusion in comprehensive therapeutic programs (Carr *et al.* 2012; Aalbers *et al.* 2017; Geretsegger *et al.* 2017; Bowling 2023).

The following sections of the article will illustrate how specific music therapy methods; e.g. working with the topic of the inner critic, modulation of emotional intensity, or facilitation of a healthy adult, can be practically incorporated into the therapeutic process for different types of patients.

Music interventions in schema therapy: techniques and therapeutic goals

The integration of musical interventions into schema therapy provides specific opportunities for working with individual modes, emotional needs, and internal conflicts of patients. While verbal psychotherapy primarily relies on dialogue and cognitive reflection, music enables direct engagement with affective experience and may facilitate rapid activation of core schemas and internal representations (Aigen 2014). In inpatient settings, a range of targeted techniques can be applied in accordance with the phase of therapy and the patient's currently dominant modes.

Working with a Vulnerable Child

The vulnerable child represents a mode in which the patient experiences pain, loneliness, fear or shame. Music-based interventions can provide a contained and supportive context in which these emotions can be accessed without overwhelming the patient. Common techniques include receptive listening to emotionally congruent music, guided musical imagery, and gentle improvisation using soft instruments. The music here functions as an emotional bridge to the needs for acceptance, comfort and understanding. A vulnerable child can also be treated through the influence of music, which creates a safe space in which emotions can not only be experienced but also processed and re-integrated at a level appropriate to our emotional-cognitive development (Bruscia 1987, Zanders 2018).

Externalizing the Critical Mode

The critical parent is often associated with an inner voice that devalues the patient and contributes to repeated self-blame. Musical techniques allow this inner part to be externalized and then worked with. For example, patients can improvise a "voice of the critic" often using chaotic, distinctive rhythms or dissonant structures, followed by reflection on their impact. Alternatively, they can create a musical contrast between the critic and the healthy adult or confrontation between these two modes, thereby strengthening the internal boundary, the ability to regulate themselves and also confidence in their own strengths.

Healthy Adult Support

The goal of schema therapy is to develop the Healthy Adult mode — an internal perspective capable of recognizing the needs of child and coping parts and responding to them with compassion and appropriate action. Music-based interventions may support this process through the creation of personally meaningful compositions, the use of stable harmonic structures, or collaborative music-making in group settings. Therapy thus becomes a setting for experiencing functional relational dynamics and Healthy Adult leadership, which could be internalized (Gooding 2011).

Managing emotional intensity and building regulation

Music can serve as a tool for regulating affect – both for its induction and for its gradual calming. Working with tempo, rhythm, and dynamics allows patients to explore their boundaries and find new ways of managing heightened emotional arousal. This is especially important for patients with borderline personality disorder, bipolar disorder or psychotic features (Pérez-Aguado *et al.* 2023).

Musical techniques are chosen to correspond to the therapeutic goals of the given phase of therapy – from increasing security and self-expression, through conflict activation, to its processing and reconstruction of the relationship to oneself.

Working with maladaptive schemas through music

One of the central goals of schema therapy is to identify and reshape deeply rooted early maladaptive schemas that arise from unmet basic emotional needs in childhood (Young *et al.* 2003). Musical interventions can significantly support this process by opening the way to emotional experiences that are not always easy to verbalize and by allowing access to affective traces that are otherwise difficult to access (Koelsch 2014).

Music can activate autobiographical memories, evoke intense emotional responses, and enhance self-reflection (Janata 2009; Koelsch 2014). In a therapeutic context, this ability can be used to confront and process early maladaptive schemas, for example through listening to thematically selected compositions, improvisation, or active music creation that expresses internal conflicts and emotional experiences associated with early maladaptive schemas of abandonment, abuse, or lack of autonomy.

Case study 1: Activating the Healthy Adult Mode through Musical Expression of the "Inner Prison"

Lenka, a 26-year-old woman hospitalized for a mixed anxiety-depressive disorder, presented with a prominent *Dependent Schema*. In both individual sessions and group discussions, she repeatedly expressed feelings of helplessness, difficulty making decisions independently, and fear of being abandoned if she asserted her own needs. These emotional patterns were deeply rooted in her early experiences with an overprotective yet emotionally unavailable mother and a passive father. In schema therapy terms, she exhibited strong activation of the *Subjugated Child* and *Compliant Surrenderer* modes, which prevented her from taking initiative or expressing her authentic self.

The patients were invited to participate in a shared, unstructured improvisation, with the goal of expressing—through music—the experiences and themes that wound or otherwise negatively affect their inner Vulnerable Child. Unstructured musical improvisation is characterized by the freedom of expression it allows, as it is not confined by external direction or structure. Lenka hesitated at first, but after a short while, she stood up from the sofa and reached for a djembe—an African drum. Her

playing revealed a strong sense of caution and a tendency to carefully listen to others, to whom she subsequently adjusted her expression. Another notable moment occurred when the surrounding instruments softened and became quieter; Lenka responded with a startled reaction and an immediate impulse to quiet herself as well, as if she was afraid of being heard.

After the group completed the improvisation, a reflective discussion followed in which Lenka was asked about the personal meaning of the improvisation and what she had attempted to express musically. Lenka shared her fear of being heard and her need to be guided, saying: "I feel like a small, helpless child. I need others to tell me what to do and how to do it—without them, I don't know who I am, and I don't know if I could make it on my own."

This spontaneous musical expression served as a non-verbal entry point into her dependent schema and the associated emotional memory of being "invisible unless she submits." During the reflection that followed the musical improvisation, the therapist leading the group discussion asked: "What was the improvisation about for you, and what did it bring up?"

Lenka responded: "It hurts when I realize I constantly have to submit. I just wait for the next command…"

The therapist followed up by asking what meaning the drum she had chosen held for her.

Lenka replied: "I wasn't aware of it at first, but now that I think about it, the drum represents strength. Strength to stand up to oppression and the possibility of being heard."

The group validated Lenka's experience, and one group member shared that it felt to him as though Lenka had taken an important step toward discovering a strength within herself—something that had always been there, even though it's hard for her to access.

The therapist responded with appreciation and added: "Lenka, I have the feeling that you chose an instrument that, perhaps unconsciously, truly gives you power and a voice. It was entirely in your hands how the improvisation—otherwise shaped by gentle melodic instruments—would develop."

Other members of the group nodded supportively, and Lenka began to cry.

This moment marked a turning point for Lenka. This moment marked a turning point for Lenka. Supported by the therapist and the group, she recognized her own strength and, for the first time, identified the inner critic's role in driving her toward submission as a form of overcompensation. Through this, she connected with her Healthy Adult mode.

After the reflection on the improvisation, the therapist invited the group to consider what their inner Vulnerable Child might need. These needs were then expressed through musical improvisation in pairs.

The group divided into pairs, with one partner taking the role of the Vulnerable Child and the other of the Nurturing Parent. Lenka expressed a wish to hear the Japanese Koshi chime, known for its gentle and soothing sound. Her partner chose this instrument and played it for her while Lenka rested and listened. After the improvisation ended, Lenka was asked what the Nurturing Parent had been trying to say to her through the music. She replied: "That I'm allowed to be free. That I don't have to do everything according to others' wishes anymore. That I deserve to be respected and accepted by others—and most of all, that I'm capable of making my own decisions."

This was the first time in therapy that Lenka had openly acknowledged the possibility of autonomy and self-direction. The group therapist identified and emphasized this moment as the emergence of the Healthy Adult—capable of soothing the Vulnerable Child, setting boundaries for the Compliant Surrenderer, and gently challenging the dependent schema.

In the following weeks, Lenka began experimenting with small steps toward autonomy — asking to lead a part of the group ritual, expressing disagreement during a conflict resolution exercise, and later discussing with her therapist a concrete plan to move out of her parent's home. These changes were repeatedly linked back to the musical representation and the symbolic shift she had experienced during the group session.

This case illustrates how creative experiential techniques such as music therapy, when embedded within the schema therapy model, can access core schemas and modes, offer a safe medium for exploration, and provide tangible moments for activating the *Healthy Adult Mode* — even in patients who initially experience themselves as passive, fearful, or dependent.

Case study 2: From Fear to Strength Through Rhythm

Veronika, a 31-year-old woman, was admitted for inpatient treatment due to generalized anxiety disorder and panic disorder. She presented with prominent symptoms related to the Defectiveness schema. She came from a family dominated by an aggressive father who directed his aggression both toward her and her mother. He frequently shouted, punished harshly, and emphasized that Veronika had no right to express opinions. She often witnessed violent arguments between her parents, including physical assaults by her father against her mother. Veronika herself was subjected to cruel punishment.

She described a pervasive sense of caution, constantly perceiving her environment as potentially dangerous. She stated, "It's like something bad could happen at any moment, and I wouldn't be able to do anything about it—because it's all my fault, because I'm worthless." Loud sounds were particularly distressing for her, evoking intense feelings of threat and vulnerability.

During a group music therapy session focused on rhythm, patients participated in a shared drumming experience. To help them familiarize themselves with the drums and explore the sounds and expressive possibilities, the therapist invited the group to imitate him. He began with a soft, gentle rhythm reminiscent of raindrops tapping on a windowsill. Gradually, the volume and intensity increased, building up to a crescendo that resembled a thunderstorm. At the peak, the entire group was playing with maximal power and speed. After reaching the climax, the intensity slowly diminished, until the group, guided by the therapist, returned to the initial soft tapping pattern.

Following the improvisation, the therapist initiated a group reflection and asked: "What was this experience about for you? What did it bring up?"

After a short pause, Veronika spoke up. She admitted that the shared drumming, especially the rising intensity, was very unpleasant. She began to tremble and was on the verge of tears. The therapist responded: "Thank you for sharing that honestly,

Veronika. Can you describe what it was about the drumming that affected you so deeply?" *This intervention corresponded to the 'Critical Mode' (see Table 1), using percussion-based confrontation to externalize internalized shame and criticism.*

With tearful eyes, Veronika explained that the sound had vividly reminded her of situations from childhood when her father became enraged—screaming at her and her mother, hitting them, and telling them they had no right to speak.

The therapist acknowledged her experience: "I understand that this must have been an incredibly painful and frightening memory of abandonment and terror. I want to say how proud I am of you for talking about this and for being able to stay with us during the exercise. I wonder—would you be willing to try the same drumming exercise again, but this time with you leading the group, and us following your rhythm? You can shape it entirely according to your own needs."

Veronika hesitated but agreed: "I'm afraid, but I want to try."

She began to play very gently and cautiously. Her rhythm resembled a soft spring rain. The others respectfully followed her lead, creating a soothing, comforting resonance. Veronika maintained a gentle dynamic and did not increase the volume. As she continued playing, she began to cry.

When the exercise concluded, the therapist asked: "I can see that leading the group brought up strong emotions. Could you share more about what it meant for you?"

Veronika responded: "When I started playing and the others joined in, I suddenly remembered those situations when my father was being aggressive. But this time, something changed. In my imagery, my mother stood up for me. She came to me and hugged me... finally. She had never done that before. It felt really good to be in control."

The therapist praised her work and gently offered a further step: "That was beautiful, Veronika. You did an amazing job. I'd like to invite you to repeat the exercise once more, but this time, in your new image where your mother embraces you, try to invite someone—anyone you choose—who could protect you both."

Veronika agreed and began to play again. Her playing started very softly but gradually grew in strength and intensity. The expression was powerful, and she eventually returned to the gentle rhythm.

After the group completed the second exercise, the therapist asked what the experience had brought for her. Veronika responded, visibly moved: "It was beautiful to feel that someone was able to protect both my vulnerable inner child and my mom. And that someone was me—as an adult. I was finally able to stand up to my father and set boundaries. He was surprised, but my inner child needed that moment of empowerment. For the first time, I felt safe. I realized that not everything that happened was my fault."

Music thus serves as a medium that not only reveals the core of maladaptive beliefs but also allows for their transformation through symbolic expression and emotional experience. However, this work requires very sensitive guidance, as re-traumatization or overwhelming intense affect can occur. Appropriate timing and integration of musical elements into a broader therapeutic framework are therefore essential.

Music as a path to corrective emotional experience

One of the key goals of schema therapy is to offer patients a corrective emotional experience that would replace previous maladaptive patterns of relationships and self-perception. In this process, music represents a specific tool that can open the way to a deeply emotional experience without the need for rational processing and thus bypass the defence mechanisms that often prevent change (Pérez-Aguado *et al.* 2023).

In a therapeutic context, music can be seen as a bridge to the child parts of the self that carry within them the pain of unmet needs, rejection or trauma. With the support of the therapist's empathy and a safe group atmosphere, an experience can arise that carries emotional closeness, acceptance and understanding, values that were often missing in the original relationships (Padesky 1994). It is precisely corrective emotional experiences that are considered one of the most powerful factors of change in psychotherapy.

When working with music, moving moments often occur – for example, when listening to a song that the patient associates with a loved one, with childhood or with loss. Emotions that are not usually expressed in ordinary conversation come to the surface thanks to the musical experience. If these moments are then processed safely in therapeutic dialogue, they can lead to profound emotional transformation (Beck 1976).

At the same time, the musical corrective experience helps to strengthen the Healthy Adult – the inner part of the self that can regulate emotions, protect the vulnerable part and establish close relationships. For example, joint improvisation in a small group can bring an experience of equality, respect and connection without judgment. This has the potential to change negative internal beliefs about oneself and others, such as "I am not good enough" or "relationships are dangerous".

Music can thus serve not merely as a supportive adjunct but as a central vehicle for therapeutic change — provided its use is clinically anchored so that emotional activation leads to understanding, acceptance, and lasting integration (Figure 1). However, the key is its sensitive and therapeutically anchored use – so that it does not only lead to an emotional experience, but to a deeper understanding, acceptance and lasting integration of the experience (Figure 1).

Case illustrations of the therapeutic process

We present five case studies of hospitalized patients with various diagnostic categories, in which a targeted integration of music therapy methods with a schema therapeutic framework was used. The first three are developed in full narrative form; Cases 4 and 5 include condensed schema development and music therapy

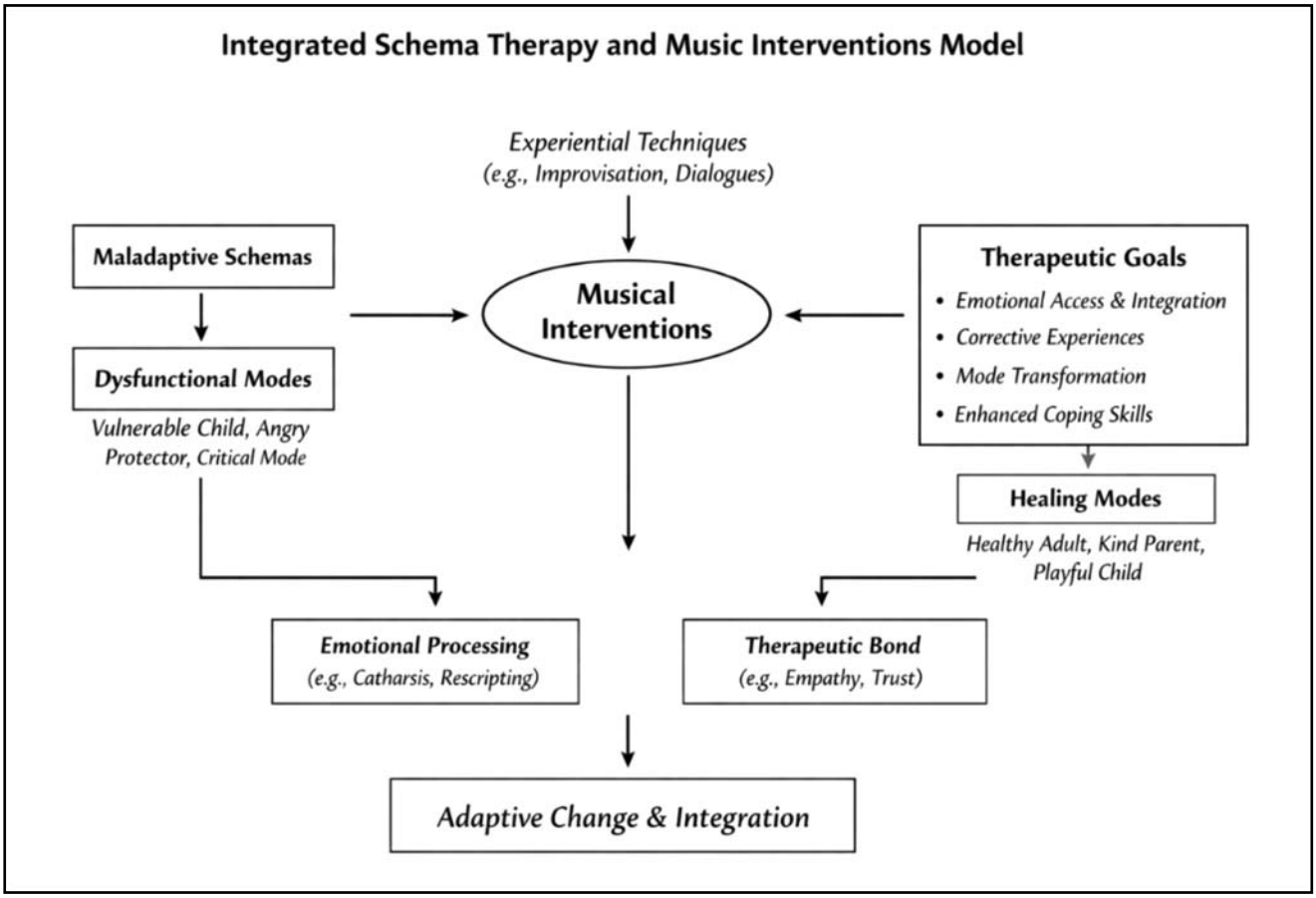

Fig. 1. A proposed clinical integration model linking schema therapy modes, music therapy interventions, and therapeutic aims in inpatient psychiatric care.
The model depicts the dynamic relationship between three core elements: (1) schema modes (inner states characterized by distinct emotional, cognitive, and behavioral patterns, as defined in Young et al. 2003); (2) music therapy techniques (including improvisation, receptive listening, song work, and rhythmic interaction); and (3) therapeutic aims (emotional access, corrective emotional experience, mode transformation, and Healthy Adult activation). Arrows or connective pathways in the figure indicate the hypothesized bidirectional influence between musical experience and mode state, mediated by the therapeutic relationship. The model is derived from clinical observation across the five cases reported in this study and from the neuroscientific literature on music, limbic activation, and self-regulation (Koelsch 2014, 2015; Blood & Zatorre 2001). It is intended as a heuristic framework to guide clinical formulation and hypothesis-driven intervention design, not as a statistically validated structural model.

accounts; all five are summarized comparatively in Table 2.. Each of the illustrations demonstrates a specific way of working with maladaptive modes and schemas through musical interventions, with an emphasis on emotional correction, insight, and activation of the Healthy Adult.

Case study 3: Depressive disorder with features of emotional deprivation

Martina, a forty-year-old woman working as an accountant, was admitted to the department for a recurrent severe depressive episode. This was her fourth hospitalization in the last ten years. Already in the initial interview, it was clear that the core of her symptoms was a deep-rooted feeling of emotional emptiness and loneliness, which, in her words, "stretches like a grey veil over my entire life."

Development of schemas and modes

Martina grew up as the youngest of five children in a family with an emotionally cold mother and an often-absent father. The father was often away at work; the mother was overworked and strict. As the patient herself described it: "Mom had a lot of us, but she was never completely present. When I tried to tell her something, she dismissed me. I often heard: 'Don't exaggerate, you are not the only one in the world.'"

From the perspective of schema therapy, the maladaptive schema of emotional deprivation was evident in her, specifically in the dimensions of lack of empathy and absence of protection. This basic need remained systematically unfulfilled in childhood. As a defence mechanism, Martina gradually developed overcompensation in the form of excessive independence, emotional detachment, and suppression of needs. In the outside world, she appeared as a competent and disciplined woman who "needs nothing" and "can do everything herself." This pattern was maintained by the excessively controlling mode of the Demanding Parent, which suppressed manifestations of vulnerability and manifested itself in the Controlling Hypercompensator. However, in difficult periods, typically in connection with abandonment or a sense of failure, a strong mode of the Vulnerable Child was activated. Martina then fell

into passive resignation and helplessness, deep sadness and physical fatigue appeared – even psychomotor retardation.

Music Therapy Experience

As part of group music therapy, she reacted strongly to the initial method of "voice touch," which is simple unison singing on one note, which the therapist leads and the group gradually joins in. She cried at this common sound. After the session, she spontaneously said:

"I don't know what happened, but suddenly I felt like I wasn't alone there. That someone was there with me. That's never happened to me before. I always feel like I'm transparent."

The subsequent reflection on this experience brought an important connection to her inner world. The following dialogue developed during the therapeutic conversation:

Music therapist: "Martina, what did you feel during that common tone? You talked about tears that came by themselves. Try to remember that moment again."

Martina: "As if… as if something inside me was released. I can't say it exactly. It was… warm and sad at the same time. But different and sad than usual. Not hopelessly."

Music therapist: "Could it have been sad because at that moment you felt something for the first time that you had missed for a long time?"

Martina (after a moment of silence): "Maybe so. As a child, I longed a lot for someone to hug me or just look at me and have an interest in their eyes. But my mother was always away or tired… And my father… he was a shadow."

Music therapist: "And that moment here in the group, when you were in unison with the others, could it have reminded me of that old, unfulfilled dream?"

Martina: "Yes. But this time it happened. There were people there. I heard them. And they heard me."

In subsequent sessions, the "musical safe place" technique was used, in which patients, accompanied by slow improvisation, imagine a place of safety and support. Martina imagined a forest clearing where she appeared as a child, sitting alone. In repeated sessions, she gradually managed to create an internal figure of a Healthy Adult, who approached the child, spoke to him and offered closeness. In one session, she touched her "Inner Girl" for the first time and after a while said:

"The first time I didn't jump her, I didn't run away, I didn't turn away. I just sat there with her."

At that moment, with tears in her eyes, she recognized that instead of hyper-compensating with caring for others and distance, the ability to remain present in one's pain – without judgment – could be healing.

Case Summary

Martina's story illustrates the profound influence of a maladaptive pattern of emotional deprivation, which was formed based on a chronic lack of empathy and support in childhood. Her hyper-compensatory strategy manifested itself as excessive independence and emotional closure, which blocked access to the Vulnerable Child and led to repeated depressive episodes. Working with voice, unison and imagination in music therapy allowed the patient to experience corrective emotional experiences that helped develop the Healthy Adult mode and the Loving Parent mode, which got in touch with the Vulnerable part of the self. The therapeutic interview after the musical experience showed how crucial it is to connect the experience with its verbalization and acceptance.

Case study 4: Bipolar affective disorder, depressive phase, Surrender and Critic modes

Adam, a twenty-nine-year-old man, was hospitalized after a third major depressive episode that followed a phase of hypomanic relaxation. He appeared resigned and slowed down, his facial expressions were almost dead and his speech was monotonous. He had a history of bipolar affective disorder type II, frequent depressions with a chronic sense of failure and less frequent but significant phases of overload. Already during the initial interview, elements of deep self-devaluation, inner criticism and passive resignation were evident. The patient repeatedly stated: "I am incapable, I will never achieve anything. People only tolerate me, but deep down I am a lost cause."

Development of schemas and modes

According to the concept of schema therapy, several maladaptive schemas were identified in Adam – primarily failure, defectiveness and dependence, which had been formed in childhood. He grew up as the youngest of twins in a family with an authoritarian father who was emotionally distant and very demanding. The father regularly criticized his son's performance, mocked his insecurities, and disregarded his boundaries. The mother was passive, rather anxious, and absent-minded. Adam recalled: "Dad always made me speak loudly, stand up straight, and not be a jerk. When I cried, it was a slap in the face."

This style of parenting created a strong pattern of defectiveness and failure, which was internally maintained by the active mode of the Inner Critic—the inner voice that tormented Adam even into adulthood: "You're not doing enough. You're lazy. Everyone else can do it, but you can't." In response to these internal demands, the Hypercompensator mode sometimes activated, typically in hypomanic phases, when Adam switched his strengths, exaggerated his performance, planned grandiose projects, and subsequently exhausted himself. However, in depressive phases, the Capitulator mode prevailed, leading to apathy, social isolation, and passivity.

Music Therapy Experience – Group Drumming

Initially, Adam was uninvolved in group music therapy. He sat to the side, avoided eye contact, and did not respond to prompts. However, in one session, during the structural rhythmic drumming method with frame drums, he suddenly grabbed the instrument and began to drum in a regular, strong four-beat rhythm. The sound was precise, emphatic, and resonated throughout the room. The rest of the group spontaneously joined in and the rhythm intensified.

After the rhythm died away, Adam sat motionless for a few seconds, and then tears started to flow. In the subsequent verbal reflection, he spontaneously said:

"Finally, I was in control of something. Not the voices in my head. Not the one who keeps saying I'm weak. This was me. I was setting the rhythm. For the first time, I could hear myself."

This experience had a strong symbolic meaning – a part of the Fighting Child emerged in it, who stood up to the inner voice of helplessness for the first time. The silence that accompanied Adam in his depressive passivity was symbolically interrupted by power and rhythm – a form that he created and that others accepted.

Individual music therapy – a dialogue of songs

This moment was followed by individual music therapy. Adam was invited to create a short-improvised song in which his inner voice would be heard. A two-part dialogue developed – first in the form of two different keys, later in the text:

Critic's Voice (low, harsh tone): "You can't do anything, you're a loser. Everyone laughs at you." Healthy Adult's Voice (softer, calmer tone): "Try to take it one step at a time. You don't have to be perfect. You can try to believe that you are more than your fear. "

As the song repeated, Adam relaxed, began to change the harmony of the second voice himself, and finally combined both voices into a harmonious chord. Tears in his eyes and a quiet sentence: "Dad would never say this. But I can say it to myself. "

Therapeutic interview after the experience

Music therapist: "Adam, what happened between those two voices? What changed?"

Adam (long silence): "For the first time it wasn't just an interrogation. I could have given that other voice a chance. And suddenly I trusted it… at least a little."

Music therapist: "How did it feel – to hear that you can be with yourself differently?"

Adam: "It was… strange. As if someone in me stood up for me for the first time. Not against me."

Music therapist: "And if that Healthy Adult voice were to continue, what would it say to that boy who is always being blamed?"

Adam (with tears): "That just because he's crying doesn't mean he's weak. That he's in it with him. That even if he fails, he still has the right to be. "

Further work and development in therapy

In the following sessions, work with the body and rhythm was developed - drumming, walking with rhythmic guitar accompaniment and imagination, where Adam imagined his "inner boy" running up the stairs from the dark basement, while the figure of the Healthy Adult was waiting at the door with an outstretched hand.

A symbolic moment was when, during a group improvisation, Adam began to give a melody in a major key himself and invited the others to join in. It was a step away from the Surrendered Child mode to the ability to stand, create and be heard - despite the presence of the inner Critic, who he was now able to recognize as the voice of the past, not the truth.

Summary of the case study

Adam's story shows the destructive power of failure, defectiveness and dependency patterns that arose in the environment of a critical father and a passive mother. Depressive phases were accompanied by a predominance of the Surrendered Child and the strict Inner Critic modes, while overcompensation was manifested in hypomanic phases. Work in music therapy – especially rhythm, voice and song improvisation – enabled the activation of the Fighting Child and the gradual development of the Healthy Adult mode. The key moments were body rhythms, the possibility of hearing oneself differently and creating one's voice, which offers empathy instead of judgment.

Case study 5: Confronting the Inner Critic Through Music

Iveta is a 24-year-old woman hospitalized in a psychotherapeutic ward for borderline personality disorder. She comes from a broken family background; her father left the family when Iveta was five. Prior to his departure, he was an alcoholic who displayed aggression when intoxicated, and was mostly passive when sober, often yielding to Iveta's mother, who was emotionally volatile and manipulative. Iveta was frequently exposed to conflicts between her intoxicated father and her mother. When the parents weren't fighting, Iveta had to be her mother's support, constantly listening to complaints about her father's behaviour, with her mother repeatedly assuming the role of the helpless victim in need of protection.

At the beginning of the therapeutic program, Iveta shared her intense anger toward her family but also toward herself. She blamed herself for not doing more to help her parents get along. A schema of unlovability and vulnerability was evident in Iveta, manifesting through a compensatory strategy of "protecting and helping everyone else."

During a music therapy session focused on working with the Inner Critic, the therapist placed animal-themed cards on the floor and asked each group member to select two. The first card was to represent a quality they already possessed and valued, and the second, a quality they still needed in their life.

Iveta chose the wolf as her first card and the dolphin as her second. When the therapist asked what these cards symbolized for her, Iveta replied: "The wolf protects its pack, it's strong and persistent. If it cares about someone, it never gives up. It's also brave because it overcomes so many challenges."

Therapist: "That's a beautiful metaphor, and I really see those qualities in you. Can we name them together?"

Iveta: "They're love and courage."

Therapist: "Perfect. I'm proud of you. Would you now introduce your second card—the quality you feel you still need?"

Iveta: "Sure, the dolphin symbolizes freedom, perspective, and joy. You know… when it swims, it often swims with someone it loves, someone it belongs to—and there's such lightness in that. It jumps, it plays… qualities like perspective and playfulness—the ability to feel joy."

Therapist: "Thank you. If you're open to it, we can now invite these strengthening qualities into the next part of our work."

Iveta looked a bit startled but bravely replied: "I'm not sure what's coming, but yes… I won't give up, I'm in."

The therapist explained that the next activity would involve a musical confrontation with Iveta's Inner Critic, assisted by the symbolic qualities she had chosen. Iveta selected a middle-aged man to represent courage and persistence, and a younger woman around her own age to embody perspective and joy. The rest of the six-member group took on the role of the Inner Critic.

Therapist: "Iveta, please describe your Inner Critic in detail—how does it behave, what does it say, what is it like? If it were a person, how would it look and express itself?"
Iveta responded promptly: "It's intrusive, with a stupid grin, whispering in my ear: 'See? You couldn't even protect your family from falling apart. You're weak. No one loves you, you poor thing. Once people find out the family broke because of you, they'll hate you.'"
Therapist: "That gives me chills… I deeply appreciate your honesty and courage."
Then to the group: "Now, those of you representing the Inner Critic—please choose instruments that reflect what we just heard. Your task is to embody the Critic through sound."
The three group members representing the Critic hesitantly picked instruments:
- an ocean drum that made a harsh rattling noise when moved roughly,
- a crystal singing bowl tuned to a very high pitch that became painfully shrill at louder volumes, and
- a violin used to create a grating, screechy tone.

The Inner Critic stood facing Iveta and began to "speak" through sound, following her description. Iveta, sitting alone in the centre, widened her eyes and soon began to cry. After about 30 seconds, the therapist stopped the playing.
Therapist: "Iveta, I see this brought up strong emotions. Can you share what's happening inside you?"
Iveta: "It's such an awful pain… how can those sounds be exactly like him? Like that voice in my head? They portrayed it so precisely. I feel sick realizing how horrible my Critic really is. I'm so afraid of it."
Therapist: "I understand, Iveta. Now is the right time to invite your strengths."
The supporting participants were asked to sit close to Iveta—so she was between them. The therapist encouraged Iveta to sense what it was like not to face the Critic alone.
Iveta took a deep belly breath and said: "It's a relief to have courage and perspective beside me."
The therapist agreed and instructed the supporting participants to symbolically protect Iveta—through posture or gesture, without speaking or playing.
The man representing courage stood between Iveta and the Critic, facing her with a kind smile. The young woman representing perspective sat close to Iveta and gently held her hand. The Inner Critic then resumed playing.
After the performance ended, the therapist asked Iveta what the experience was like this time.
Iveta: "It's incredible… to feel protected even when someone knows what's going on in my head. I could still hear the Critic, but much less than before… I felt accepted."
Therapist: "Now you have the chance to choose instruments—you and your strengths—and confront the Critic."
Iveta chose the delicate Koshi chime. The man representing courage selected a drum, and the young woman representing perspective chose a xylophone.
Therapist: "Excellent. You're now entering a musical confrontation. Choose your strategy. The Inner Critic should remain aware of what thoughts and emotions arise during the process."
The confrontation began. The Critic played loudly, forcefully. But the steady rhythm of the drum (courage) and the soft melodic tones of the Koshi chime and xylophone (Iveta and perspective) gradually began to shine through. The Critic's sound weakened, until eventually, only the calm tones of Iveta's Koshi and her supporters could be heard. Iveta stood up during the confrontation. Peace was restored. The session ended in silence.

Reflection
Therapist: "Thank you all, that was powerful. I'd like to ask each of you what this shared experience brought up."
Iveta: "It's unbelievable… I think I understand my Critic better now—but I also understand myself. I need resources that fill me with joy. I noticed that when I tried to fight aggressively, it drained me and made the Critic stronger… I need courage and perspective to stay consistent. I need joy to recharge, so that the Critic eventually tires out on its own."
Courage: "This was an important experience for me. It helped me realize the power I carry. It was an honor to protect you, Iveta."
Joy: "I really felt for you, Iveta. I just had to squeeze your hand and add playfulness to your Koshi chime with the tones of the xylophone."
The Inner Critics: "It was deeply unpleasant to hurt someone you care about—even symbolically. Especially knowing the Inner Critic is a liar and a jerk. And yes, the more Iveta tried to push back, the more I got into character and wanted to overpower her… What disarmed me was when she focused on herself and her inner strengths. Suddenly, we were powerless—it was frustrating."
Therapist: "That makes total sense. This wasn't easy, but you all handled it with bravery. I'm grateful and proud of you. Now, those who played the Inner Critic are invited—but not required—to show support for Iveta."
It was important that those who represented the Critic also had the chance to switch sides and support Iveta—which they all did.

Case Summary
Iveta's story is an example of a patient with a profound disruption of the self-relationship framework, who lived in long-term overcompensation, under the influence of a schema of not deserving love, defectiveness, and social isolation. The predominant modes were the Withdrawn Surrendered Child and the Hyper compensator. Thanks to structurally and sensitively guided music therapy, she managed to activate the Healthy Adult mode, restore contact with her true self, and establish the first relationship bridges. Music became a safe environment in which she could express a basic human need – to be heard and accepted – without having to risk being overwhelmed or rejected.

Comparison with other integrative approaches

Integrating music therapy into schema therapy is still an emerging field, with few established frameworks in the literature. However, there are several related integrative approaches that offer valuable points of comparison. For example, Geller & Porges (2014) emphasize the role

Tab. 2. Comparative overview of five inpatient case studies integrating music therapy with schema therapy

Patient	Diagnosis (ICD-10)	Predominant Modes	Main Interventions	Short-Term Change	Long-Term Change
Lenka	F60.3 (Emotionally unstable personality disorder, borderline type)	Compliant Surrender, Vulnerable Child	Percussion-based empowerment, dual improvisation, imagery of nurturing message	Emergence of Healthy Adult, increased self-expression	Reduced submissiveness, improved assertiveness in group context
Iveta	F60.3 (Emotionally unstable personality disorder, borderline type)	Hypercompensator, Surrendered Child	Instrumental confrontation with Inner Critic, redefinition of personal values through sound	Emotional release, softened perfectionism	Increased flexibility, clarified self-worth and needs
Veronika	F41.0, F41.1 (Panic disorder and generalized anxiety disorder)	Defective Self, Vulnerable Child	Rhythm-based activation, guided re-imagining with symbolic protection	Emotional breakthrough, positive imagery, tears and calm	Emerging inner protector, reduced shame and fear of loud sounds
Antonín	F31.1 (Bipolar affective disorder, current episode manic, without psychotic symptoms)	Overcompensator, Angry Child	Musical boundary work, mirroring via structured improvisation	Heightened awareness of control dynamics	Improved emotional regulation and group collaboration
Marta	F20.0 (Paranoid schizophrenia, stabilized state)	Detached Protector, Vulnerable Child	Joint musical activation, sensory-focused improvisation	Engagement with group, initial emotion access	Gradual increase in emotional resonance and participation

Each row represents one anonymized patient. Diagnosis is recorded according to ICD-10 criteria as assigned by the treating psychiatric team. Predominant schema modes lists the modes most consistently activated during the treatment course, using Young et al. (2003) terminology. Primary music therapy interventions describes the technique or format most centrally used with that patient (e.g., group drumming, receptive listening, paired improvisation, Inner Critic externalization). Short-term changes refers to shifts observed within the hospitalization period, based on therapist session notes, audio recordings, and patient reflections. Long-term changes refers to changes documented across subsequent sessions or reported at later follow-up within the inpatient stay; post-discharge outcomes were not systematically assessed. Patient names are pseudonyms. Cases 1 (Lenka), 2 (Veronika), and 5 (Iveta) are developed as full narrative case presentations in the body of the article; Cases 3 (Martina) and 4 (Adam) are summarized here with condensed clinical accounts.

of music and vocal attunement in polyvagal-informed psychotherapy, highlighting how musical elements can support emotional co-regulation and the development of a felt sense of safety. In psychodynamic music therapy, authors like Fachner *et al.*. (2019) explore how improvisation facilitates access to unconscious material, serving a similar function to imagery and dialogue in schema therapy.

In the field of trauma therapy, the work of Bensimon *et al.* (2008) demonstrates the use of rhythm-based interventions (e.g., drumming) to support affect regulation in individuals with post-traumatic stress disorder. These findings parallel the use of structured musical experiences to stabilize vulnerable child modes and reduce dissociative symptoms in schema-informed work.

Some cognitive-behavioral approaches have also begun to incorporate expressive methods. For example, expressive writing or imagery rescripting with music (e.g., Lang *et al.* 2012) have shown promise in addressing early maladaptive schemas by creating emotionally corrective experiences.

Compared to these approaches, our integrative model uniquely emphasizes the *mode model of schema therapy* and uses music as a *medium for dialogue between modes*, for example, between the Vulnerable Child and the Kind Parent. This distinguishes our work from more general music therapy integrations and places it within a structured conceptual map that supports case formulation and therapeutic planning.

Discussion

Benefits, challenges and limits of integration

This study addresses two important research questions: (1) How can specific musical interventions facilitate access to, and transformation of, schema modes in psychiatric inpatients? (2) What observable clinical effects emerge from this integration in short-term and long-term therapy outcomes?

Integrating music therapy into schema therapy offers a number of unique benefits, but also brings with it specific challenges and limitations that need to be

reflected in the planning and implementation of this combined intervention.

Benefits of combining music therapy and schema therapy

A musical environment can serve as a safe and emotionally rich framework for engaging with vulnerable parts of the self, especially the Vulnerable Child mode. In many cases, the nonverbal approach facilitates engagement with deeply held emotions that are otherwise difficult to access in ordinary verbal dialogue (Gold *et al.* 2009). Patients often report that through music they "felt more than ever" and that this has enabled them to be more truthful to themselves and the group.

Combining musical techniques with the concept of modes and maladaptive schemas allows the therapist to target the intervention at specific parts of the patient's inner world – for example, to strengthen the Healthy Adult, confront the Critical Parent, or support self-expression in the Struggling Child mode. Music thus does not only act as a support but becomes a direct tool for change in the schema therapy framework (Table 2).

Challenges and Limitations

One of the main pitfalls is the variability in individual patient reactivity to musical stimuli. While some patients experience music intervention as deeply healing, others may experience overload or re-traumatization, especially if the music unintentionally evokes unprocessed traumatic memories (Pérez-Aguado *et al.* 2023). For this reason, the therapist's sensitivity and ability to work flexibly with the level of exposure are important (Table 3).

Another challenge is the need for combined expertise – the therapist should understand both the principles of music therapy and the basics of schema therapy, including the conceptualization of the client based on schemas and modes. This can be limiting in clinical practice if interdisciplinary cooperation or specialized training is lacking.

In a group format, it can be challenging to maintain a balance between individual depth of intervention and the need to maintain a safe framework for the entire team. Working with music often opens up intense emotions that require adequate anchoring and subsequent integration into the therapeutic conversation.

Several limitations of this study warrant acknowledgment. First, all five cases were drawn from a single inpatient department in the Czech Republic; cultural, linguistic, and healthcare-system factors may limit transferability. Second, the therapeutic dialogues were conducted in Czech and presented here in translation; nuances of affective expression may have been partially lost in rendering. Third, the authors served simultaneously as treating clinicians and case reporters, a dual role that introduces potential confirmation bias in case selection and interpretation. Fourth, none of the cases document concurrent pharmacotherapy, which is standard in inpatient psychiatric care and may have contributed to observed emotional shifts independently of music intervention.

Recommendations for clinical practice

The integration of music therapy into the framework of schema therapy brings inspiring possibilities for working with deep emotional cores and rigid patterns of experience and behaviour. Based on current clinical experience and a review of the available literature, several specific recommendations can be formulated for its application in practice and further research directions. The proposed integration model offers a structured yet adaptable therapeutic protocol, allowing for mode-specific musical strategies to be systematically applied based on clinical formulation.

(1) Secure anchoring in a therapeutic framework

Working with music can activate intense emotional experiences, so it is essential to ensure a sufficiently safe context. Music interventions should be structured to support emotional regulation and integration of experiences (Bruscia 1987, Zanders 2018). Special attention should be paid to gradually establishing contact with sensitive modes, such as the Vulnerable Child or the Compliant Surrender mode.

(2) Flexible adaptation of techniques to the patient's current needs

Musical instruments and forms should be chosen individually – from listening techniques to improvisation to therapeutic songs. The therapist takes into account

Tab. 3. Possible barriers to integrating music interventions into schema therapy and recommended strategies for addressing them

Barrier	Problem description	Recommended solution
Patient's resistance to music	Negative experiences, shame, lack of relationship with music	Gradual introduction, passive listening option
Emotional overload/dissociation during activity	Approaching painful topics too quickly	Anchoring in the present, regulation through Healthy Adult
Expectations of artistic performance	Fear of failure, perfectionism	Normalization, safe environment, non-verbal approach
Lack of musical skills by the therapist	Fear of incompetence, technical limits	Short training, simple tools, group facilitation

the patient's current dominant modes, preferences and level of introspection (Carr *et al.* 2013).

(3) Promoting cooperation between disciplines
Given the need for expertise in both areas, interdisciplinary collaboration or additional competencies through further education would be advisable. Workshops or courses that link schema therapy and music therapy could increase accessibility for a wider group of therapists.

(4) Use of group format
Group schema therapy supplemented with musical elements allows for the development of corrective experiences in a safe peer environment, promotes mentalization, and reinforces healthy relationship patterns (Farrell *et al.* 2014). However, it also requires an experienced facilitator who can lead the group even with emotionally demanding content.

Future research should prioritise: (1) single-case experimental designs (SCED) to measure intra-session affect regulation changes; (2) mixed-method pre-post designs using validated instruments (e.g., the Schema Mode Inventory) to assess mode accessibility before and after music interventions; (3) standardised session manuals with fidelity measures for each of the mode-specific musical strategies outlined in Table 1; and (4) controlled studies comparing this integrative model against schema therapy alone and music therapy alone.

Conclusion

The integration of music therapy into the framework of schema therapy represents an innovative and potentially clinically beneficial approach that enables deeper contact with emotional needs, strengthens healthy modes and supports corrective emotional experiences. Music, with its potential to bypass cognitive defences and activate unconscious layers of experience, opens up space for authentic emotional expression and a new form of relational connection with the therapist and the group.

The presented case studies show that the combination of music interventions with schema therapy principles can bring significant shifts in patients' self-concept, emotion regulation and the ability to create more functional relationship patterns. At the same time, however, this approach places increased demands on therapeutic readiness, sensitive timing of interventions and careful integration of experiences into the broader context of therapy.

Despite positive clinical experiences, the area of integration of music therapy and schema therapy remains insufficiently covered in research. Further empirical studies are needed to verify the effectiveness of this approach and to develop standardized methodologies. Interdisciplinary cooperation between psychotherapists and music therapists appears to be key to the sustainable development of this area.

Music within schema therapy can therefore become not only a means of expressive work, but also a bridge to healing old wounds, building healthy parenting attitudes, and strengthening healthy adult modes. If used sensitively and following therapeutic goals, it has the potential to become a valuable part of multimodal psychotherapeutic intervention for patients with complex personality disorders.

The proposed integrative model offers a structured yet flexible approach that may enrich therapeutic work across various clinical settings and inspire future empirical studies. Furthermore, future research should aim to develop standardized manuals for musical interventions targeting specific schema modes, including fidelity measures and therapist training protocols, to enable replication and broader dissemination of this approach.

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 (ChatGPT, OpenAI) were used to support language editing and stylistic refinement. All clinical content, case analyses, theoretical frameworks, and conclusions were produced solely by the authors, who take full responsibility for the final manuscript.

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