

## Chapter 1

# SCHEMA THERAPY: CONCEPTUAL MODEL

Schema therapy is an innovative, integrative therapy developed by Young and colleagues (Young, 1990, 1999) that significantly expands on traditional cognitive-behavioral treatments and concepts. The therapy blends elements from cognitive-behavioral, attachment, Gestalt, object relations, constructivist, and psychoanalytic schools into a rich, unifying conceptual and treatment model.

Schema therapy provides a new system of psychotherapy that is especially well suited to patients with entrenched, chronic psychological disorders who have heretofore been considered difficult to treat. In our clinical experience, patients with full-blown personality disorders, as well as those with significant characterological issues that underlie their Axis I disorders, typically respond extremely well to schema-focused treatment (sometimes in combination with other treatment approaches).

### THE EVOLUTION FROM COGNITIVE TO SCHEMA THERAPY

A look at the field of cognitive-behavioral therapy<sup>1</sup> helps to explain the reason Young felt that the development of schema therapy was so impor-

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<sup>1</sup>In this section, we use the term “cognitive-behavioral therapy” to refer to various protocols that have been developed by writers such as Beck (Beck, Rush, Shaw, & Emery, 1979) and Barlow (Craske, Barlow, & Meadows, 2000) to treat Axis I disorders.

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tant. Cognitive-behavioral researchers and practitioners have made excellent progress in developing effective psychological treatments for Axis I disorders, including many mood, anxiety, sexual, eating, somatoform, and substance abuse disorders. These treatments have traditionally been short term (roughly 20 sessions) and have focused on reducing symptoms, building skills, and solving problems in the patient's current life.

However, although many patients are helped by these treatments, many others are not. Treatment outcome studies usually report high success rates (Barlow, 2001). For example, in depression, the success rate is over 60% immediately after treatment, but the relapse rate is about 30% after 1 year (Young, Weinberger, & Beck, 2001)—leaving a significant number of patients unsuccessfully treated. Often patients with underlying personality disorders and characterological issues fail to respond fully to traditional cognitive-behavioral treatments (Beck, Freeman, & Associates, 1990). One of the challenges facing cognitive-behavioral therapy today is developing effective treatments for these chronic, difficult-to-treat patients.

Characterological problems can reduce the effectiveness of traditional cognitive-behavioral therapy in a number of ways. Some patients present for treatment of Axis I symptoms, such as anxiety or depression, and either fail to progress in treatment or relapse once treatment is withdrawn. For example, a female patient presents for cognitive-behavioral treatment of agoraphobia. Through a program consisting of breathing training, challenging catastrophic thoughts, and graduated exposure to phobic situations, she significantly reduces her fear of panic symptoms and overcomes her avoidance of numerous situations. Once treatment ends, however, the patient lapses back into her agoraphobia. A lifetime of dependence, along with feelings of vulnerability and incompetence—what we call her Dependence and Vulnerability schemas—prevent her from venturing out into the world on her own. She lacks the self-confidence to make decisions and has failed to acquire such practical skills as driving, navigating her surroundings, managing money, and selecting proper destinations. She prefers instead to let significant others make the necessary arrangements. Without the guidance of the therapist, the patient cannot orchestrate the public excursions necessary to maintain her treatment gains.

Other patients come initially for cognitive-behavioral treatment of Axis I symptoms. After these symptoms have been resolved, their characterological problems become a focus of treatment. For example, a male patient undergoes cognitive-behavioral therapy for his obsessive-compulsive disorder.

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Some cognitive-behavioral therapists have adapted these protocols to work with difficult patients in ways that are consistent with schema therapy (c.f. Beck, Freeman, & Associates, 1990). We discuss some of these modifications later in this chapter (see pp. 48–53). For the most part, however, current treatment protocols within cognitive-behavioral therapy do not reflect these adaptations.

der. Through a short-term behavioral program of exposure combined with response prevention, he largely eliminates the obsessive thoughts and compulsive rituals that had consumed most of his waking life. Once his Axis I symptoms have abated, however, and he has time to resume other activities, he must face the almost complete absence of a social life that is a result of his solitary lifestyle. The patient has what we call a “Defectiveness schema,” with which he copes by avoiding social situations. He is so acutely sensitive to perceived slights and rejections that, since childhood, he has avoided most personal interaction with others. He must grapple with his lifelong pattern of avoidance if he is ever to develop a rewarding social life.

Still other patients who come for cognitive-behavioral treatment lack specific symptoms to serve as targets of therapy. Their problems are vague or diffuse and lack clear precipitants. They feel that something vital is wrong or missing from their lives. These are patients whose presenting problems *are* their characterological problems: They come seeking treatment for chronic difficulties in their relationships with significant others or in their work. Because they either do not have significant Axis I symptoms or have so many of them, traditional cognitive-behavioral therapy is difficult to apply to them.

### Assumptions of Traditional Cognitive-Behavioral Therapy Violated by Characterological Patients

Traditional cognitive-behavioral therapy makes several assumptions about patients that often prove untrue of those patients with characterological problems. These patients have a number of psychological attributes that distinguish them from straightforward Axis I cases and make them less suitable candidates for cognitive-behavioral treatment.

One such assumption is that patients will comply with the treatment protocol. Standard cognitive-behavioral therapy assumes that patients are motivated to reduce symptoms, build skills, and solve their current problems and that, therefore, with some prodding and positive reinforcement, they will comply with the necessary treatment procedures. However, for many characterological patients, their motivations and approaches to therapy are complicated, and they are often unwilling or unable to comply with cognitive-behavioral therapy procedures. They may not complete homework assignments. They may demonstrate great reluctance to learn self-control strategies. They may appear more motivated to obtain consolation from the therapist than to learn strategies for helping themselves.

Another such assumption in cognitive-behavioral therapy is that, with brief training, patients can access their cognitions and emotions and report them to the therapist. Early in therapy, patients are expected to observe and record their thoughts and feelings. However, patients with characterological problems are often unable to do so. They often seem out of

touch with their cognitions or emotions. Many of these patients engage in cognitive and affective avoidance. They block disturbing thoughts and images. They avoid looking deeply into themselves. They avoid their own disturbing memories and negative feelings. They also avoid many of the behaviors and situations that are essential to their progress. This pattern of avoidance probably develops as an instrumental response, learned because it is reinforced by the reduction of negative affect. Negative emotions such as anxiety or depression are triggered by stimuli associated with childhood memories, prompting avoidance of the stimuli in order to avoid the emotions. Avoidance becomes a habitual and exceedingly difficult to change strategy for coping with negative affect.

Cognitive-behavioral therapy also assumes that patients can change their problematic cognitions and behaviors through such practices as empirical analysis, logical discourse, experimentation, gradual steps, and repetition. However, for characterological patients, this is often not the case. In our experience, their distorted thoughts and self-defeating behaviors are extremely resistant to modification solely through cognitive-behavioral techniques. Even after months of therapy, there is often no sustained improvement.

Because characterological patients usually lack psychological flexibility, they are much less responsive to cognitive-behavioral techniques and frequently do not make meaningful changes in a short period of time. Rather, they are psychologically rigid. Rigidity is a hallmark of personality disorders (American Psychiatric Association, 1994, p. 633). These patients tend to express hopelessness about changing. Their characterological problems are ego-syntonic: Their self-destructive patterns seem to be so much a part of who they are that they cannot imagine altering them. Their problems are central to their sense of identity, and to give them up can seem like a form of death—a death of a part of the self. When challenged, these patients rigidly, reflexively, and sometimes aggressively cling to what they already believe to be true about themselves and the world.

Cognitive-behavioral therapy also assumes that patients can engage in a collaborative relationship with the therapist within a few sessions. Difficulties in the therapeutic relationship are typically not a major focus of cognitive-behavioral treatments. Rather, such difficulties are viewed as obstacles to be overcome in order to attain the patient's compliance with treatment procedures. The therapist–patient relationship is not generally regarded as an “active ingredient” of the treatment. However, patients with characterological disorders often have difficulty forming a therapeutic alliance, thus mirroring their difficulties in relating to others outside of therapy. Many difficult-to-treat patients have had dysfunctional interpersonal relationships that began early in life. Lifelong disturbances in relationships with significant others are another hallmark of personality disorders (Millon, 1981). These patients often find it difficult to form secure thera-

peutic relationships. Some of these patients, such as those with borderline or dependent personality disorders, frequently become so absorbed in trying to get the therapist to meet their emotional needs that they are unable to focus on their own lives outside of therapy. Others, such as those with narcissistic, paranoid, schizoid, or obsessive–compulsive personality disorders, are frequently so disengaged or hostile that they are unable to collaborate with the therapist. Because interpersonal issues are often the core problem, the therapeutic relationship is one of the best areas for assessing and treating these patients—a focus that is most often neglected in traditional cognitive-behavioral therapy.

Finally, in cognitive-behavioral treatment, the patient is presumed to have problems that are readily discernible as targets of treatment. In the case of patients with characterological problems, this presumption is often not met. These patients commonly have presenting problems that are vague, chronic, and pervasive. They are unhappy in major life areas and have been dissatisfied for as long as they can remember. Perhaps they have been unable to establish a long-term romantic relationship, have failed to reach their potential in their work, or experience their lives as empty. They are fundamentally dissatisfied in love, work, or play. These very broad, hard-to-define life themes usually do not make easy-to-address targets for standard cognitive-behavioral treatment.

Later we look at how specific schemas can make it difficult for patients to benefit from standard cognitive-behavioral therapy.

## THE DEVELOPMENT OF SCHEMA THERAPY

For the many reasons just described, Young (1990, 1999) developed schema therapy to treat patients with chronic characterological problems who were not being adequately helped by traditional cognitive-behavioral therapy: the “treatment failures.” He developed schema therapy as a systematic approach that expands on cognitive-behavioral therapy by integrating techniques drawn from several different schools of therapy. Schema therapy can be brief, intermediate, or longer term, depending on the patient. It expands on traditional cognitive-behavioral therapy by placing much greater emphasis on exploring the childhood and adolescent origins of psychological problems, on emotive techniques, on the therapist–patient relationship, and on maladaptive coping styles.

Once acute symptoms have abated, schema therapy is appropriate for the treatment of many Axis I and Axis II disorders that have a significant basis in lifelong characterological themes. Therapy is often undertaken in conjunction with other modalities, such as cognitive-behavioral therapy and psychotropic medication. Schema therapy is designed to treat the chronic characterological aspects of disorders, not acute psychiatric symp-

toms (such as full-blown major depression or recurring panic attacks). Schema therapy has proven useful in treating chronic depression and anxiety, eating disorders, difficult couples problems, and long-standing difficulties in maintaining satisfying intimate relationships. It has also been helpful with criminal offenders and in preventing relapse among substance abusers.

Schema therapy addresses the core psychological themes that are typical of patients with characterological disorders. As we discuss in detail in the next section, we call these core themes Early Maladaptive Schemas. Schema therapy helps patients and therapists to make sense of chronic, pervasive problems and to organize them in a comprehensible manner. The model traces these schemas from early childhood to the present, with particular emphasis on the patient's interpersonal relationships. Using the model, patients gain the ability to view their characterological problems as ego-dystonic and thus become more empowered to give them up. The therapist allies with patients in fighting their schemas, utilizing cognitive, affective, behavioral, and interpersonal strategies. When patients repeat dysfunctional patterns based on their schemas, the therapist empathically confronts them with the reasons for change. Through "limited reparenting," the therapist supplies many patients with a partial antidote to needs that were not adequately met in childhood.

## EARLY MALADAPTIVE SCHEMAS

### History of the Schema Construct

We now turn to a detailed look at the basic constructs that make up schema theory. We begin with the history and development of the term "schema."

The word "schema" is utilized in many fields of study. In general terms, a schema is a structure, framework, or outline. In early Greek philosophy, Stoic logicians, especially Chrysippus (ca. 279–206 B.C.), presented principles of logic in the form of "inference schemata" (Nussbaum, 1994). In Kantian philosophy, a schema is a conception of what is common to all members of a class. The term is also used in set theory, algebraic geometry, education, literary analysis, and computer programming, to name just some of the diverse fields in which the concept of a "schema" is used.

The term "schema" has an especially rich history within psychology, most widely in the area of cognitive development. Within cognitive development, a schema is a pattern imposed on reality or experience to help individuals explain it, to mediate perception, and to guide their responses. A schema is an abstract representation of the distinctive characteristics of an event, a kind of blueprint of its most salient elements. In psychology the

term is probably most commonly associated with Piaget, who wrote in detail about schemata in different stages of childhood cognitive development. Within cognitive psychology, a schema can also be thought of as an abstract cognitive plan that serves as a guide for interpreting information and solving problems. Thus we may have a linguistic schema for understanding a sentence or a cultural schema for interpreting a myth.

Moving from cognitive psychology to cognitive therapy, Beck (1967) referred in his early writing to schemas. However, in the context of psychology and psychotherapy, a schema can be thought of generally as any broad organizing principle for making sense of one's life experience. An important concept with relevance for psychotherapy is the notion that schemas, many of which are formed early in life, continue to be elaborated and then superimposed on later life experiences, even when they are no longer applicable. This is sometimes referred to as the need for "cognitive consistency," for maintaining a stable view of oneself and the world, even if it is, in reality, inaccurate or distorted. By this broad definition, a schema can be positive or negative, adaptive or maladaptive; schemas can be formed in childhood or later in life.

### Young's Definition of a Schema

Young (1990, 1999) hypothesized that some of these schemas—especially schemas that develop primarily as a result of toxic childhood experiences—might be at the core of personality disorders, milder characterological problems, and many chronic Axis I disorders. To explore this idea, he defined a subset of schemas that he labeled Early Maladaptive Schemas.

Our revised, comprehensive definition of an Early Maladaptive Schema is:

- a broad, pervasive theme or pattern
- comprised of memories, emotions, cognitions, and bodily sensations
- regarding oneself and one's relationships with others
- developed during childhood or adolescence
- elaborated throughout one's lifetime and
- dysfunctional to a significant degree

Briefly, Early Maladaptive Schemas are self-defeating emotional and cognitive patterns that begin early in our development and repeat throughout life. Note that, according to this definition, an individual's behavior is not part of the schema itself; Young theorizes that maladaptive behaviors develop as *responses* to a schema. Thus behaviors are *driven* by schemas but are not part of schemas. We explore this concept more when we discuss coping styles later in this chapter.

## CHARACTERISTICS OF EARLY MALADAPTIVE SCHEMAS

Let us now examine some of the main characteristics of schemas. (From this point on, we use the terms “schema” and “Early Maladaptive Schema” virtually interchangeably.) Consider patients who have one of the four most powerful and damaging schemas from our list of 18 (see Figure 1.1 on pp. 14–17): Abandonment/Instability, Mistrust/Abuse, Emotional Deprivation, and Defectiveness/Shame. As young children, these patients were abandoned, abused, neglected, or rejected. In adulthood their schemas are triggered by life events that they perceive (unconsciously) as similar to the traumatic experiences of their childhood. When one of these schemas is triggered, they experience a strong negative emotion, such as grief, shame, fear, or rage.

Not all schemas are based in childhood trauma or mistreatment. Indeed, an individual can develop a Dependence/Incompetence schema without experiencing a single instance of childhood trauma. Rather, the individual might have been completely sheltered and overprotected throughout childhood. However, although not all schemas have trauma as their origin, all of them are destructive, and most are caused by noxious experiences that are repeated on a regular basis throughout childhood and adolescence. The effect of all these related toxic experiences is cumulative, and together they lead to the emergence of a full-blown schema.

Early Maladaptive Schemas fight for survival. As we mentioned earlier, this is the result of the human drive for consistency. The schema is what the individual knows. Although it causes suffering, it is comfortable and familiar. It feels “right.” People feel drawn to events that trigger their schemas. This is one reason schemas are so hard to change. Patients regard schemas as a priori truths, and thus these schemas influence the processing of later experiences. They play a major role in how patients think, feel, act, and relate to others and paradoxically lead them to inadvertently recreate in their adult lives the conditions in childhood that were most harmful to them.

Schemas begin in early childhood or adolescence as reality-based representations of the child’s environment. It has been our experience that individuals’ schemas fairly accurately reflect the tone of their early environment. For example, if a patient tells us that his family was cold and unaffectionate when he was young, he is usually correct, even though he may not understand *why* his parents had difficulty showing affection or expressing feelings. His attributions for their behavior may be wrong, but his basic sense of the emotional climate and how he was treated is almost always valid.

The dysfunctional nature of schemas usually becomes most apparent later in life, when patients continue to perpetuate their schemas in their

interactions with other people even though their perceptions are no longer accurate. Early Maladaptive Schemas and the maladaptive ways in which patients learn to cope with them often underlie chronic Axis I symptoms, such as anxiety, depression, substance abuse, and psychosomatic disorders.

Schemas are dimensional, meaning they have different levels of severity and pervasiveness. The more severe the schema, the greater the number of situations that activate it. So, for example, if an individual experiences criticism that comes early and frequently, that is extreme, and that is given by both parents, then that individual's contact with almost anyone is likely to trigger a Defectiveness schema. If an individual experiences criticism that comes later in life and is occasional, milder, and given by only one parent, then that individual is less likely to activate the schema later in life; for example, the schema may be triggered only by demanding authority figures of the critical parent's gender. Furthermore, in general, the more severe the schema, the more intense the negative affect when the schema is triggered and the longer it lasts.

As we mentioned earlier, there are positive and negative schemas, as well as early and later schemas. Our focus is almost exclusively on Early Maladaptive Schemas, so we do not spell out these positive, later schemas in our theory. However, some writers have argued that, for each of our Early Maladaptive Schemas, there is a corresponding adaptive schema (see Elliott's polarity theory; Elliott & Lassen, 1997). Alternatively, considering Erikson's (1950) psychosocial stages, one could argue that the successful resolution of each stage results in an adaptive schema, whereas the failure to resolve a stage leads to a maladaptive schema. Nevertheless, our concern in this book is the population of psychotherapy patients with chronic disorders rather than a normal population; therefore, we focus primarily on the early *maladaptive* schemas that we believe underlie personality pathology.

## THE ORIGINS OF SCHEMAS

### Core Emotional Needs

Our basic view is that schemas result from unmet core emotional needs in childhood. We have postulated five core emotional needs for human beings.<sup>2</sup>

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<sup>2</sup>Our list of needs is derived from both the theories of others and our own clinical observation and has not been tested empirically. Ultimately, we hope to conduct research on this subject. We are open to revision based on research and have revised the list over time. The list of domains (see Figure 1.1 on pp. 14–17) is also open to modification based on empirical findings and clinical experience.

1. Secure attachments to others (includes safety, stability, nurturance, and acceptance)
2. Autonomy, competence, and sense of identity
3. Freedom to express valid needs and emotions
4. Spontaneity and play
5. Realistic limits and self-control

We believe that these needs are universal. Everyone has them, although some individuals have stronger needs than others. A psychologically healthy individual is one who can adaptively meet these core emotional needs.

The interaction between the child's innate temperament and early environment results in the frustration, rather than gratification, of these basic needs. The goal of schema therapy is to help patients find adaptive ways to meet their core emotional needs. All of our interventions are means to this end.

### Early Life Experiences

Toxic childhood experiences are the primary origin of Early Maladaptive Schemas. The schemas that develop earliest and are the strongest typically originate in the nuclear family. To a large extent, the dynamics of a child's family are the dynamics of that child's entire early world. When patients find themselves in adult situations that activate their Early Maladaptive Schemas, what they usually are experiencing is a drama from their childhood, usually with a parent. Other influences, such as peers, school, groups in the community, and the surrounding culture, become increasingly important as the child matures and may lead to the development of schemas. However, schemas developed later are generally not as pervasive or as powerful. (Social Isolation is an example of a schema that is usually developed later in childhood or in adolescence and that may not reflect the dynamics of the nuclear family.)

We have observed four types of early life experiences that foster the acquisition of schemas. The first is *toxic frustration of needs*. This occurs when the child experiences too little of a good thing and acquires schemas such as Emotional Deprivation or Abandonment through deficits in the early environment. The child's environment is missing something important, such as stability, understanding, or love. The second type of early life experience that engenders schemas is *traumatization* or *victimization*. Here, the child is harmed or victimized and develops schemas such as Mistrust/Abuse, Defectiveness/Shame, or Vulnerability to Harm. In the third type, the child experiences too much of a good thing: The parents provide the child with too much of something that, in moderation, is healthy for a child. With schemas such as Dependence/Incompetence or Entitlement/Grandiosity, for example, the child is rarely mistreated. Rather, the child is

coddled or indulged. The child's core emotional needs for autonomy or realistic limits are not met. Thus parents may be overly involved in the life of a child, may overprotect a child, or may give a child an excessive degree of freedom and autonomy without any limits.

The fourth type of life experience that creates schemas is *selective internalization or identification with significant others*. The child selectively identifies with and internalizes the parent's thoughts, feelings, experiences, and behaviors. For example, two patients present for treatment, both survivors of childhood abuse. As a child, the first one, Ruth, succumbed to the victim role. When her father hit her, she did not fight back. Rather, she became passive and submissive. She was the victim of her father's abusive behavior, but she did not internalize it. She experienced the feeling of being a victim, but she did not internalize the feeling of being an abuser. The second patient, Kevin, fought back against his abusive father. He identified with his father, internalized his aggressive thoughts, feelings, and behavior, and eventually became abusive himself. (This example is extreme. In reality, most children both absorb the experience of being a victim and take on some of the thoughts, feelings, or behaviors of the toxic adult.)

As another example, two patients both present with Emotional Deprivation schemas. As children, both had cold parents. Both felt lonely and unloved as children. Should we assume that, as adults, both had become emotionally cold? Not necessarily. Although both patients know what it means to be recipients of coldness, they are not necessarily cold themselves. As we discuss later in the section on coping styles, instead of identifying with their cold parents, patients might cope with their feelings of deprivation by becoming nurturing, or, alternatively, they might cope by becoming demanding and feeling entitled. Our model does not assume that children identify with and internalize everything their parents do; rather, we have observed that they *selectively* identify with and internalize certain aspects of significant others. Some of these identifications and internalizations become schemas, and some become coping styles or modes.

We believe that temperament partly determines whether an individual identifies with and internalizes the characteristics of a significant other. For example, a child with a dysthymic temperament will probably not internalize a parent's optimistic style of dealing with misfortune. The parent's behavior is so contrary to the child's disposition that the child cannot assimilate it.

### Emotional Temperament

Factors other than early childhood environment also play major roles in the development of schemas. The child's emotional temperament is especially important. As most parents soon realize, each child has a unique and distinct "personality" or temperament from birth. Some children are more irritable, some are more shy, some are more aggressive. There is a great

deal of research supporting the importance of the biological underpinnings of personality. For example, Kagan and his colleagues (Kagan, Reznick, & Snidman, 1988) have generated a body of research on temperamental traits present in infancy and have found them to be remarkably stable over time.

Following are some dimensions of emotional temperament that we hypothesize might be largely inborn and relatively unchangeable through psychotherapy alone.

Labile ↔ Nonreactive  
 Dysthymic ↔ Optimistic  
 Anxious ↔ Calm  
 Obsessive ↔ Distractible  
 Passive ↔ Aggressive  
 Irritable ↔ Cheerful  
 Shy ↔ Sociable

One might think of temperament as the individual's unique mix of points on this set of dimensions (as well as other aspects of temperament that will undoubtedly be identified in the future).

Emotional temperament interacts with painful childhood events in the formation of schemas. Different temperaments selectively expose children to different life circumstances. For example, an aggressive child might be more likely to elicit physical abuse from a violent parent than a passive, appeasing child. In addition, different temperaments render children differentially susceptible to similar life circumstances. Given the same parental treatment, two children might react very differently. For example, consider two boys who are both rejected by their mothers. The shy child hides from the world and becomes increasingly withdrawn and dependent on his mother; the sociable one ventures forth and makes other, more positive connections. Indeed, sociability has been shown to be a prominent trait of resilient children, who thrive despite abuse or neglect.

In our observation, an extremely favorable or aversive early environment can override emotional temperament to a significant degree. For example, a safe and loving home environment might make even a shy child quite friendly in many situations; alternatively, if the early environment is rejecting enough, even a sociable child may become withdrawn. Similarly, an extreme emotional temperament can override an ordinary environment and produce psychopathology without apparent justification in the patient's history.

### SCHEMA DOMAINS AND EARLY MALADAPTIVE SCHEMAS

In our model, the 18 schemas are grouped into five broad categories of unmet emotional needs that we call "schema domains." We review the empir-

ical support for these 18 schemas later in the chapter. In this section we elaborate on the five domains and list the schemas they contain. In Figure 1.1, the five schema domains are centered, in italics, without numbers (e.g., “*Disconnection and Rejection*”); the 18 schemas are aligned to the left and numbered (e.g., “1. Abandonment/Instability”).

### Domain I: Disconnection and Rejection

Patients with schemas in this domain are unable to form secure, satisfying attachments to others. They believe that their needs for stability, safety, nurturance, love, and belonging will not be met. Typical families of origin are unstable (*Abandonment/Instability*), abusive (*Mistrust/Abuse*), cold (*Emotional Deprivation*), rejecting (*Defectiveness/Shame*), or isolated from the outside world (*Social Isolation/Alienation*). Patients with schemas in the Disconnection and Rejection domain (especially the first four schemas) are often the most damaged. Many had traumatic childhoods, and as adults they tend to rush headlong from one self-destructive relationship to another or to avoid close relationships altogether. The therapy relationship is often central to the treatment of these patients.

The *Abandonment/Instability* schema is the perceived instability of one’s connection to significant others. Patients with this schema have the sense that important people in their life will not continue to be there because they are emotionally unpredictable, they are only present erratically, they will die, or they will leave the patient for someone better.

Patients who have the *Mistrust/Abuse* schema have the conviction that, given the opportunity, other people will use the patient for their own selfish ends. For example, they will abuse, hurt, humiliate, lie to, cheat, or manipulate the patient.

The *Emotional Deprivation* schema is the expectation that one’s desire for emotional connection will not be adequately fulfilled. We identify three forms: (1) deprivation of *nurturance* (the absence of affection or caring); (2) deprivation of *empathy* (the absence of listening or understanding); and (3) deprivation of *protection* (the absence of strength or guidance from others).

The *Defectiveness/Shame* schema is the feeling that one is flawed, bad, inferior, or worthless and that one would be unlovable to others if exposed. The schema usually involves a sense of shame regarding one’s perceived defects. Flaws may be private (e.g., selfishness, aggressive impulses, unacceptable sexual desires) or public (e.g., unattractive appearance, social awkwardness).

The *Social Isolation/Alienation* schema is the sense of being different from or not fitting into the larger social world outside the family. Typically, patients with this schema do not feel they belong to any group or community.

**FIGURE 1.1.** Early maladaptive schemas with associated schema domains.***Disconnection and Rejection***

*(The expectation that one's needs for security, safety, stability, nurturance, empathy, sharing of feelings, acceptance, and respect will not be met in a predictable manner. Typical family origin is detached, cold, rejecting, withholding, lonely, explosive, unpredictable, or abusive.)*

**1. Abandonment/Instability**

The perceived *instability* or *unreliability* of those available for support and connection.

Involves the sense that significant others will not be able to continue providing emotional support, connection, strength, or practical protection because they are emotionally unstable and unpredictable (e.g., have angry outbursts), unreliable, or present only erratically; because they will die imminently; or because they will abandon the individual in favor of someone better.

**2. Mistrust/Abuse**

The expectation that others will hurt, abuse, humiliate, cheat, lie, manipulate, or take advantage. Usually involves the perception that the harm is intentional or the result of unjustified and extreme negligence. May include the sense that one always ends up being cheated relative to others or "getting the short end of the stick."

**3. Emotional Deprivation**

The expectation that one's desire for a normal degree of emotional support will not be adequately met by others. The three major forms of deprivation are:

- A. **Deprivation of Nurturance:** Absence of attention, affection, warmth, or companionship.
- B. **Deprivation of Empathy:** Absence of understanding, listening, self-disclosure, or mutual sharing of feelings from others.
- C. **Deprivation of Protection:** Absence of strength, direction, or guidance from others.

**4. Defectiveness/Shame**

The feeling that one is defective, bad, unwanted, inferior, or invalid in important respects or that one would be unlovable to significant others if exposed. May involve hypersensitivity to criticism, rejection, and blame; self-consciousness, comparisons, and insecurity around others; or a sense of shame regarding one's perceived flaws. These flaws may be **private** (e.g., selfishness, angry impulses, unacceptable sexual desires) or **public** (e.g., undesirable physical appearance, social awkwardness).

**5. Social Isolation/Alienation**

The feeling that one is isolated from the rest of the world, different from other people, and/or not part of any group or community.

***Impaired Autonomy and Performance***

*(Expectations about oneself and the environment that interfere with one's perceived ability to separate, survive, function independently, or perform successfully. Typical family origin is enmeshed, undermining of child's confidence, overprotective, or failing to reinforce child for performing competently outside the family.)*

(cont.)

**FIGURE 1.1.** (cont.)**6. Dependence/Incompetence**

Belief that one is unable to handle one's *everyday responsibilities* in a competent manner, without considerable help from others (e.g., take care of oneself, solve daily problems, exercise good judgment, tackle new tasks, make good decisions). Often presents as helplessness.

**7. Vulnerability to Harm or Illness**

Exaggerated fear that *imminent* catastrophe will strike at any time and that one will be unable to prevent it. Fears focus on one or more of the following: (A) *Medical catastrophes* (e.g., heart attacks, AIDS); (B) *Emotional catastrophes* (e.g., going crazy); (C) *External catastrophes* (e.g., elevators collapsing, victimization by criminals, airplane crashes, earthquakes).

**8. Enmeshment/Undeveloped Self**

Excessive emotional involvement and closeness with one or more significant others (often parents) at the expense of full individuation or normal social development. Often involves the belief that at least one of the enmeshed individuals cannot survive or be happy without the constant support of the other. May also include feelings of being smothered by or fused with others or insufficient individual identity. Often experienced as a feeling of emptiness and foundering, having no direction, or in extreme cases questioning one's existence.

**9. Failure**

The belief that one has failed, will inevitably fail, or is fundamentally inadequate relative to one's peers in areas of *achievement* (school, career, sports, etc.). Often involves beliefs that one is stupid, inept, untalented, lower in status, less successful than others, and so forth.

**Impaired Limits**

*(Deficiency in internal limits, responsibility to others, or long-term goal orientation. Leads to difficulty respecting the rights of others, cooperating with others, making commitments, or setting and meeting realistic personal goals. Typical family origin is characterized by permissiveness, overindulgence, lack of direction, or a sense of superiority rather than appropriate confrontation, discipline, and limits in relation to taking responsibility, cooperating in a reciprocal manner, and setting goals. In some cases, the child may not have been pushed to tolerate normal levels of discomfort or may not have been given adequate supervision, direction, or guidance.)*

**10. Entitlement/Grandiosity**

The belief that one is superior to other people; entitled to special rights and privileges; or not bound by the rules of reciprocity that guide normal social interaction. Often involves insistence that one should be able to do or have whatever one wants, regardless of what is realistic, what others consider reasonable, or the cost to others; or an exaggerated focus on superiority (e.g., being among the most successful, famous, wealthy) in order to achieve *power* or *control* (not primarily for attention or approval). Sometimes includes excessive competitiveness toward or domination of others: asserting one's power, forcing one's point of view, or controlling the behavior of others in line with one's own desires without empathy or concern for others' needs or feelings.

**11. Insufficient Self-Control/Self-Discipline**

Pervasive difficulty or refusal to exercise sufficient self-control and frustration tolerance to achieve one's personal goals or to restrain the excessive expression of one's emotions

(cont.)

**FIGURE 1.1.** (cont.)

and impulses. In its milder form, the patient presents with an exaggerated emphasis on **discomfort avoidance**: avoiding pain, conflict, confrontation, responsibility, or overexertion at the expense of personal fulfillment, commitment, or integrity.

#### **Other-Directedness**

*(An excessive focus on the desires, feelings, and responses of others, at the expense of one's own needs in order to gain love and approval, maintain one's sense of connection, or avoid retaliation. Usually involves suppression and lack of awareness regarding one's own anger and natural inclinations. Typical family origin is based on conditional acceptance: Children must suppress important aspects of themselves in order to gain love, attention, and approval. In many such families, the parents' emotional needs and desires—or social acceptance and status—are valued more than the unique needs and feelings of each child.)*

#### **12. Subjugation**

Excessive surrendering of control to others because one feels *coerced*—submitting in order to avoid anger, retaliation, or abandonment. The two major forms of subjugation are:

- A. **Subjugation of needs**: Suppression of one's preferences, decisions, and desires.
- B. **Subjugation of emotions**: Suppression of emotions, especially anger.

Usually involves the perception that one's own desires, opinions, and feelings are not valid or important to others. Frequently presents as excessive compliance, combined with hypersensitivity to feeling trapped. Generally leads to a buildup of anger, manifested in maladaptive symptoms (e.g., passive-aggressive behavior, uncontrolled outbursts of temper, psychosomatic symptoms, withdrawal of affection, "acting out," substance abuse).

#### **13. Self-Sacrifice**

Excessive focus on *voluntarily* meeting the needs of others in daily situations at the expense of one's own gratification. The most common reasons are: to prevent causing pain to others; to avoid guilt from feeling selfish; or to maintain the connection with others perceived as needy. Often results from an acute sensitivity to the pain of others. Sometimes leads to a sense that one's own needs are not being adequately met and to resentment of those who are taken care of. (Overlaps with concept of codependency.)

#### **14. Approval-Seeking/Recognition-Seeking**

Excessive emphasis on gaining approval, recognition, or attention from other people or on fitting in at the expense of developing a secure and true sense of self. One's sense of esteem is dependent primarily on the reactions of others rather than on one's own natural inclinations. Sometimes includes an overemphasis on status, appearance, social acceptance, money, or achievement as means of gaining *approval, admiration, or attention* (not primarily for power or control). Frequently results in major life decisions that are inauthentic or unsatisfying or in hypersensitivity to rejection.

#### **Overvigilance and Inhibition**

*(Excessive emphasis on suppressing one's spontaneous feelings, impulses, and choices or on meeting rigid, internalized rules and expectations about performance and ethical behavior, often at the expense of happiness, self-expression, relaxation, close*

*(cont.)*

**FIGURE 1.1.** (cont.)

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*relationships, or health. Typical family origin is grim, demanding, and sometimes punitive: performance, duty, perfectionism, following rules, hiding emotions, and avoiding mistakes predominate over pleasure, joy, and relaxation. There is usually an undercurrent of pessimism and worry that things could fall apart if one fails to be vigilant and careful at all times.)*

**15. Negativity/Pessimism**

A pervasive, lifelong focus on the negative aspects of life (pain, death, loss, disappointment, conflict, guilt, resentment, unsolved problems, potential mistakes, betrayal, things that could go wrong, etc.) while minimizing or neglecting the positive or optimistic aspects. Usually includes an exaggerated expectation—in a wide range of work, financial, or interpersonal situations—that things will eventually go seriously wrong or that aspects of one's life that seem to be going well will ultimately fall apart. Usually involves an inordinate fear of making mistakes that might lead to financial collapse, loss, humiliation, or being trapped in a bad situation. Because they exaggerate potential negative outcomes, these individuals are frequently characterized by chronic worry, vigilance, complaining, or indecision.

**16. Emotional Inhibition**

The excessive inhibition of spontaneous action, feeling, or communication, usually to avoid disapproval by others, feelings of shame, or losing control of one's impulses. The most common areas of inhibition involve: (a) inhibition of *anger* and aggression; (b) inhibition of *positive impulses* (e.g., joy, affection, sexual excitement, play); (c) difficulty expressing *vulnerability* or *communicating* freely about one's feelings, needs, and so forth; or (d) excessive emphasis on *rationality* while disregarding emotions.

**17. Unrelenting Standards/Hypercriticalness**

The underlying belief that one must strive to meet very high *internalized standards* of behavior and performance, usually to avoid criticism. Typically results in feelings of pressure or difficulty slowing down and in hypercriticalness toward oneself and others. Must involve significant impairment in pleasure, relaxation, health, self-esteem, sense of accomplishment, or satisfying relationships.

Unrelenting standards typically present as (a) **perfectionism**, inordinate attention to detail, or an underestimate of how good one's own performance is relative to the norm; (b) **rigid rules** and "shoulds" in many areas of life, including unrealistically high moral, ethical, cultural, or religious precepts; or (c) preoccupation with **time and efficiency**, the need to accomplish more.

**18. Punitiveness**

The belief that people should be harshly punished for making mistakes. Involves the tendency to be angry, intolerant, punitive, and impatient with those people (including oneself) who do not meet one's expectations or standards. Usually includes difficulty forgiving mistakes in oneself or others because of a reluctance to consider extenuating circumstances, allow for human imperfection, or empathize with feelings.

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## Domain II: Impaired Autonomy and Performance

Autonomy is the ability to separate from one's family and to function independently comparable to people one's own age. Patients with schemas in this domain have expectations about themselves and the world that interfere with their ability to differentiate themselves from parent figures and function independently. When these patients were children, typically their parents did everything for them and overprotected them; or, at the opposite (much more rare) extreme, hardly ever cared for or watched over them. (Both extremes lead to problems in the autonomy realm.) Often their parents undermined their self-confidence and failed to reinforce them for performing competently outside the home. Consequently, these patients are not able to forge their own identities and create their own lives. They are not able to set personal goals and master the requisite skills. With respect to competence, they remain children well into their adult lives.

Patients with the *Dependence/Incompetence* schema feel unable to handle their everyday responsibilities without substantial help from others. For example, they feel unable to manage money, solve practical problems, use good judgment, undertake new tasks, or make good decisions. The schema often presents as pervasive passivity or helplessness.

*Vulnerability to Harm or Illness* is the exaggerated fear that catastrophe will strike at any moment and that one will be unable to cope. Fears focus on the following types of catastrophes: (1) *medical* (e.g., heart attacks, diseases such as AIDS); (2) *emotional* (e.g., going crazy, losing control); and (3) *external* (e.g., accidents, crime, natural catastrophes).

Patients with the *Enmeshment/Undeveloped Self* schema are often overly involved with one or more significant others (often parents) to the detriment of their full individuation and social development. These patients frequently believe that at least one of the enmeshed individuals could not function without the other. The schema may include feelings of being smothered by or fused with others or lacking a clear sense of identity and direction.

The *Failure* schema is the belief that one will inevitably fail in areas of achievement (e.g., school, sports, career) and that, in terms of achievement, one is fundamentally inadequate relative to one's peers. The schema often involves beliefs that one is unintelligent, inept, untalented, or unsuccessful.

## Domain III: Impaired Limits

Patients with schemas in this domain have not developed adequate internal limits in regard to reciprocity or self-discipline. They may have difficulty respecting the rights of others, cooperating, keeping commitments, or meeting long-term goals. These patients often present as selfish, spoiled, irresponsible, or narcissistic. They typically grew up in families

that were overly permissive and indulgent. (Entitlement can sometimes be a form of overcompensation for another schema, such as Emotional Deprivation; in these cases, overindulgence is usually not the primary origin, as we discuss in Chapter 10.) As children, these patients were not required to follow the rules that apply to everyone else, to consider others, or to develop self-control. As adults they lack the capacity to restrain their impulses and to delay gratification for the sake of future benefits.

The *Entitlement/Grandiosity* schema is the assumption that one is superior to other people, and therefore entitled to special rights and privileges. Patients with this schema do not feel bound by the rules of reciprocity that guide normal social interaction. They often insist that they should be able to do whatever they want, regardless of the cost to others. They may maintain an exaggerated focus on superiority (e.g., being among the most successful, famous, wealthy) in order to achieve power. These patients are often overly demanding or dominating, and lack empathy.

Patients with the *Insufficient Self-Control/Self-Discipline* schema either cannot or will not exercise sufficient self-control and frustration tolerance to achieve their personal goals. These patients do not regulate the expression of their emotions and impulses. In the milder form of this schema, patients present with an exaggerated emphasis on discomfort avoidance. For example, they avoid most conflict or responsibility.

#### Domain IV: Other-Directedness

The patients in this domain place an excessive emphasis on meeting the needs of others rather than their own needs. They do this in order to gain approval, maintain emotional connection, or avoid retaliation. When interacting with others, they tend to focus almost exclusively on the responses of the other person rather than on their own needs, and often lack awareness of their own anger and preferences. As children, they were not free to follow their natural inclinations. As adults, rather than being directed internally, they are directed externally and follow the desires of others. The typical family origin is based on conditional acceptance: Children must restrain important aspects of themselves in order to obtain love or approval. In many such families, the parents value their own emotional needs or social “appearances” more than they value the unique needs of the child.

The *Subjugation* schema is an excessive surrendering of control to others because one feels coerced. The function of subjugation is usually to avoid anger, retaliation, or abandonment. The two major forms are: (1) *subjugation of needs*: suppressing one’s preferences or desires; and (2) *subjugation of emotions*: suppressing one’s emotional responses, especially anger. The schema usually involves the perception that one’s own needs and feelings are not valid or important. It frequently presents as excessive compliance and eagerness to please, combined with hypersensitivity to feeling

trapped. Subjugation generally leads to a buildup of anger, manifested in maladaptive symptoms (e.g., passive-aggressive behavior, uncontrolled temper outbursts, psychosomatic symptoms, or withdrawal of affection).

Patients with the *Self-Sacrifice* schema voluntarily meet the needs of others at the expense of their own gratification. They do this in order to spare others pain, avoid guilt, gain self-esteem, or maintain an emotional connection with someone they see as needy. The schema often results from an acute sensitivity to the suffering of others. It involves the sense that one's own needs are not being adequately met and may lead to feelings of resentment. This schema overlaps with the 12-step concept of "co-dependency."

Patients with the *Approval-Seeking/Recognition-Seeking* schema value gaining approval or recognition from other people over developing a secure and genuine sense of self. Their self-esteem is dependent on the reactions of others rather than on their own reactions. The schema often includes an excessive preoccupation with social status, appearance, money, or success as a means of gaining approval or recognition. It frequently results in major life decisions that are inauthentic and unsatisfying.

#### Domain V: Overvigilance and Inhibition

Patients in this domain suppress their spontaneous feelings and impulses. They often strive to meet rigid, internalized rules about their own performance at the expense of happiness, self-expression, relaxation, close relationships, or good health. The typical origin is a childhood that was grim, repressed, and strict and in which self-control and self-denial predominated over spontaneity and pleasure. As children, these patients were not encouraged to play and pursue happiness. Rather, they learned to be hypervigilant to negative life events and to regard life as bleak. These patients usually convey a sense of pessimism and worry, fearing that their lives could fall apart if they fail to be alert and careful at all times.

The *Negativity/Pessimism* schema is a pervasive, lifelong focus on the negative aspects of life (e.g., pain, death, loss, disappointment, conflict, betrayal) while minimizing the positive aspects. The schema usually includes an exaggerated expectation that things will eventually go seriously wrong in a wide range of work, financial, or interpersonal situations. These patients have an inordinate fear of making mistakes that might lead to financial collapse, loss, humiliation, or being trapped in a bad situation. Because these patients exaggerate potential negative outcomes, they are frequently characterized by worry, apprehensiveness, hypervigilance, complaining, and indecision.

Patients with *Emotional Inhibition* constrain their spontaneous actions, feelings, and communication. They usually do this to prevent being criticized or losing control of their impulses. The most common areas of

inhibition involve: (1) inhibition of *anger*; (2) inhibition of *positive impulses* (e.g., joy, affection, sexual excitement, playfulness); (3) difficulty expressing *vulnerability*; and (4) emphasis on *rationality* while disregarding emotions. These patients often present as flat, constricted, withdrawn, or cold.

The *Unrelenting Standards/Hypercriticalness* schema is the sense that one must strive to meet very high internalized standards, usually in order to avoid disapproval or shame. The schema typically results in feelings of constant pressure and hypercriticalness toward oneself and others. To be considered an Early Maladaptive Schema, there must be significant impairment in the patient's health, self-esteem, relationships, or experience of pleasure. The schema typically presents as: (1) *perfectionism* (e.g., the need to do things "right," inordinate attention to detail, or underestimating one's level of performance); (2) *rigid rules* and "shoulds" in many areas of life, including unrealistically high moral, cultural, or religious standards; or (3) preoccupation with *time and efficiency*.

The *Punitiveness* schema is the conviction that people should be harshly punished for making mistakes. The schema involves the tendency to be angry and intolerant with those people (including oneself) who do not meet one's standards. It usually includes difficulty forgiving mistakes because one is reluctant to consider extenuating circumstances, to allow for human imperfection, or to take a person's intentions into account.

### Case Illustration

Let us consider a brief case vignette that illustrates the schema concept. A young woman named Natalie comes for treatment. Natalie has an Emotional Deprivation schema: Her predominant experience of intimate relationships is that her emotional needs are not met. This has been true since early childhood. Natalie was an only child with emotionally cold parents. Although they met all of her physical needs, they did not nurture her or give her sufficient attention or affection. They did not try to understand who she was. In her family, Natalie felt alone.

Natalie's presenting problem is chronic depression. She tells her therapist that she has been depressed her whole life. Although she has been in and out of therapy for years, her depression persists. Natalie has generally been attracted to emotionally depriving men. Her husband, Paul, fits this pattern. When Natalie goes to Paul for holding or sympathy, he becomes irritated and pushes her away. This triggers her Emotional Deprivation schema, and she becomes angry. Her anger is partially justified but also partially an overreaction to a husband who loves her but does not know how to show it.

Natalie's anger further alienates her husband, and he distances himself from her even more, thus perpetuating her schema of deprivation. The marriage is caught in a vicious cycle, driven by her schema. In her marriage, Natalie continues to live out her childhood deprivation. Before mar-

rying, Natalie had dated a more emotionally demonstrative man, but she was not sexually attracted to him and felt “suffocated” by normal expressions of tenderness. This tendency to be most attracted to partners who trigger a core schema is one we commonly observe in our patients (“schema chemistry”).

This example illustrates how early childhood deprivation leads to the development of a schema, which is then unwittingly played out and perpetuated in later life, leading to dysfunctional relationships and chronic Axis I symptoms.

### Conditional versus Unconditional Schemas

We originally believed that the main difference between Early Maladaptive Schemas and Beck’s underlying assumptions (Beck, Rush, Shaw, & Emery, 1979) was that schemas are unconditional, whereas underlying assumptions are conditional. We now view some schemas as conditional and others as unconditional. Generally, the schemas that are developed earliest and are most at the core are unconditional beliefs about the self and others, whereas the schemas that are developed later are conditional.

Unconditional schemas hold out no hope to the patient. No matter what the individual does, the outcome will be the same. The individual will be incompetent, fused, unlovable, a misfit, endangered, bad—and nothing can change it. The schema encapsulates what was done to the child, without the child having had any choice in the matter. The schema simply *is*. In contrast, conditional schemas hold out the possibility of hope. The individual might change the outcome. The individual can subjugate, self-sacrifice, seek approval, inhibit emotions, or strive to meet high standards and, in so doing, perhaps avert the negative outcome, at least temporarily.

#### *Unconditional schemas*

Abandonment/Instability  
 Mistrust/Abuse  
 Emotional Deprivation  
 Defectiveness  
 Social Isolation  
 Dependence/Incompetence  
 Vulnerability to Harm or Illness  
 Enmeshment/Undeveloped Self  
 Failure  
 Negativity/Pessimism  
 Punitiveness  
 Entitlement/Grandiosity  
 Insufficient Self-Control/Self-Discipline

#### *Conditional schemas*

Subjugation  
 Self-Sacrifice  
 Approval-Seeking/Recognition-Seeking  
 Emotional Inhibition  
 Unrelenting Standards/  
 Hypercriticalness

Conditional schemas often develop as attempts to get relief from the unconditional schemas. In this sense, conditional schemas are “secondary.” Here are some examples:

*Unrelenting Standards in response to Defectiveness.* The individual believes, “If I can be perfect, then I will be worthy of love.”

*Subjugation in response to Abandonment.* The individual believes, “If I do whatever the other person wants and never get angry about it, then the person will stay with me.”

*Self-Sacrifice in response to Defectiveness.* “If I meet all of this individual’s needs and ignore my own, then the individual will accept me despite my flaws, and I will not feel so unlovable.”

It is usually impossible to meet the demands of conditional schemas all of the time. For example, it is hard to subjugate oneself totally and never get angry. It is hard to be demanding enough to get all of one’s needs met or self-sacrificing enough to meet all of the other individual’s needs. At most the conditional schemas can forestall the core schemas. The individual is bound to fall short and thus have to face the truth of the core schema once again. (Not all conditional schemas can be linked to earlier ones. These schemas are conditional only in the sense that, if the child does what is expected, feared consequences can often be avoided.)

### How Schemas Interfere with Traditional Cognitive-Behavioral Therapy

Many Early Maladaptive Schemas have the potential to sabotage traditional cognitive-behavioral therapy. Schemas make it difficult for patients to meet many of the assumptions of traditional cognitive-behavioral therapy noted previously in this chapter. For example, in regard to the assumption that patients can form a positive therapeutic alliance fairly quickly, patients who have schemas in the Disconnection and Rejection domain (Abandonment, Mistrust/Abuse, Emotional Deprivation, Defectiveness/Shame) may not be able to establish this kind of uncomplicated positive bond in a short period of time. Similarly, in terms of the presumption that patients have a strong sense of identity and clear life goals to guide the selection of treatment objectives, patients with schemas in the Impaired Autonomy and Performance domain (Dependence, Vulnerability, Enmeshment/Undeveloped Self, Failure) may not know who they are and what they want and thus may be unable to set specific treatment goals.

Cognitive-behavioral therapy assumes that patients can access cognitions and emotions and verbalize them in therapy. Patients with schemas in the Other-Directedness domain (Subjugation, Self-Sacrifice, Approval-

Seeking) may be too focused on ascertaining what the therapist wants to look within themselves or to speak about their own thoughts and feelings. Finally, cognitive-behavior therapy assumes that patients can comply with treatment procedures. Patients with schemas in the Impaired Limits domain (Entitlement, Insufficient Self-Control/Self-Discipline) may be too unmotivated or undisciplined to do so.

### EMPIRICAL SUPPORT FOR EARLY MALADAPTIVE SCHEMAS

A considerable amount of research has been done on Young's Early Maladaptive Schemas. Most research conducted thus far has been done using the long form of the Young Schema Questionnaire (Young & Brown, 1990), although studies with the short form are in progress. The Young Schema Questionnaire has been translated into many languages, including French, Spanish, Dutch, Turkish, Japanese, Finnish, and Norwegian.

The first comprehensive investigation of its psychometric properties was conducted by Schmidt, Joiner, Young, and Telch (1995). Results from this study produced alpha coefficients for each Early Maladaptive Schema that ranged from .83 (Enmeshment/Undeveloped Self) to .96 (Defectiveness/Shame) and test-retest coefficients from .50 to .82 in a nonclinical population. The primary subscales demonstrated high test-retest reliability and internal consistency. The questionnaire also demonstrated good convergent and discriminant validity on measures of psychological distress, self-esteem, cognitive vulnerability to depression, and personality disorder symptomatology.

The investigators conducted a factor analysis using both clinical and nonclinical samples. The samples revealed similar sets of primary factors that closely matched Young's clinically developed schemas and their hypothesized hierarchical relationships. Within one sample of undergraduate college students, 17 factors emerged, including 15 of the 16 originally proposed by Young (1990). One original schema, Social Undesirability, did not emerge, whereas two other unaccounted factors did. In an effort to cross-validate this factor structure, Schmidt et al. (1995) gave the Young Schema Questionnaire to a second sample of undergraduates taken from the same population. Using the same factor-analytic technique, the investigators found that, of the 17 factors produced in the first analysis, 13 were clearly replicated in the second sample. The investigators also found three distinct higher order factors. Within a sample of patients, 15 factors emerged, including 15 of the 16 originally proposed by Young (1990). These 15 factors accounted for 54% of the total variance (Schmidt et al., 1995).

In this study, the Young Schema Questionnaire demonstrated convergent validity with a test of personality disorder symptomatology (Personality Diagnostic Questionnaire—Revised; Hyler, Rieder, Spitzer, & Williams,

1987). It also demonstrated discriminant validity with measures of depression (Beck Depression Inventory; Beck, Ward, Mendelson, Mock, & Erbaugh, 1961) and self-esteem (Rosenberg Self-Esteem Questionnaire; Rosenberg, 1965) in a nonclinical undergraduate population.

This study was replicated by Lee, Taylor, and Dunn (1999) using an Australian clinical population. The investigators conducted a factor analysis. In accord with previous findings, 16 factors emerged as primary components, including 15 of the 16 originally proposed by Young. Only the Social Undesirability scale was not supported. (We have since eliminated Social Undesirability as a separate schema and merged it with Defectiveness.) In addition, a higher order factor analysis closely fit some of the schema domains proposed by Young. Overall, this study shows that the Young Schema Questionnaire possesses very good internal consistency and that its primary factor structure is stable across clinical samples from two different countries and for different diagnoses.

Lee and his colleagues (1999) discuss some reasons that the two studies produced somewhat different factor structures depending on whether a clinical or normal population was used. They conclude that the student samples probably had range effects, as it was unlikely that many of the students were suffering from extreme forms of psychopathology. The authors state that factor structure replication depends on the assumption that the schemas underlying psychopathology in clinical populations are also present in a random sample of college students. Young suggests that Early Maladaptive Schemas are indeed present in normal populations but that they become exaggerated and extreme in clinical populations.

Other studies have examined the validity of the individual schemas and how well they support Young's model. Freeman (1999) explored the use of Young's schema theory as an explanatory model for nonrational cognitive processing. Using normal participants, Freeman found that weaker endorsement of Early Maladaptive Schemas was predictive of greater interpersonal adjustment. This finding is consistent with Young's tenet that Early Maladaptive Schemas are by definition negative and dysfunctional.

Rittenmeyer (1997) examined the convergent validity of Young's schema domains with the Maslach Burnout Inventory (Maslach & Jackson, 1986), a self-report inventory designed to assess the negative impact of stressful life events. In a sample of California schoolteachers, Rittenmeyer (1997) found that two schema domains, Overconnection and Exaggerated Standards, correlated strongly with the Emotional Exhaustion scale of the Maslach Burnout Inventory. The Overconnection schema domain also correlated, although not as strongly, with two other inventory scales, Depersonalization and Personal Accomplishment.

Carine (1997) investigated the utility of Young's schema theory in the treatment of personality disorders by using Early Maladaptive

Schemas as predictor variables in a discriminant function analysis. Specifically, Carine looked at whether the presence of Young's schemas discriminated patients with DSM-IV Axis II psychopathology from patients with other types of psychopathology. Carine found that group membership in the Axis II cluster was predicted correctly 83% of the time. In support of Young's theory, Carine also found that affect appears to be an intrinsic part of schemas.

Although the Young Schema Questionnaire was not designed to measure specific DSM-IV personality disorders, significant associations appear between Early Maladaptive Schemas and personality disorder symptoms (Schmidt et al., 1995). The total score correlates highly with the total score on the Personality Diagnostic Questionnaire—Revised (Hyler et al., 1987), a self-report measure of DSM-III-R personality pathology. In this study, the schemas of Insufficient Self-Control/Self-Discipline and Defectiveness had the strongest associations with personality disorder symptoms. Individual schemas have been found to be significantly associated with theoretically relevant personality disorders. For example, Mistrust/Abuse is highly associated with paranoid personality disorder; Dependence is associated with dependent personality disorder; Insufficient Self-Control/Self-Discipline is associated with borderline personality disorder; and Unrelenting Standards is associated with obsessive-compulsive personality disorder (Schmidt et al., 1995).

## THE BIOLOGY OF EARLY MALADAPTIVE SCHEMAS

In this section we propose a biological view of schemas based on recent research on emotion and the biology of the brain (LeDoux, 1996). We stress that this section advances *hypotheses* about possible mechanisms of schema development and change. Research has not yet been undertaken to establish whether these hypotheses are valid.

Recent research suggests that there is not one emotional system in the brain but several. Different emotions are involved with different survival functions—responding to danger, finding food, having sex and finding mates, caring for offspring, social bonding—and each seems to be mediated by its own brain network. We focus on the brain network associated with fear conditioning and trauma.

### Brain Systems Involved with Fear Conditioning and Trauma

Studies on the biology of the brain indicate locations at which schema triggering based on traumatic childhood events such as abandonment or abuse might occur in the brain. In his summary of the research on the biology of traumatic memories, LeDoux (1996) writes:

During a traumatic learning situation, conscious memories are laid down by a system involving the hippocampus and related cortical areas, and unconscious memories established by fear conditioning mechanisms operating through an amygdala-based system. These two systems operate in parallel and store different kinds of information relevant to the experience. And when stimuli that were present during the initial trauma are later encountered, each system can potentially retrieve its memories. In the case of the amygdala system, retrieval results in expression of bodily responses that prepare for danger, and in the case of the hippocampal system, conscious remembrances occur. (p. 239)

Thus, according to LeDoux, the brain mechanisms that register, store, and retrieve memories of the emotional significance of a traumatic event are different from the mechanisms that process conscious memories and cognitions about the same event. The amygdala stores the emotional memory, and the hippocampus and neocortex store the cognitive memory. Emotional responses can occur without the participation of the higher processing systems of the brain—those involved in thinking, reasoning, and consciousness.

### *Characteristics of the Amygdala System*

According to LeDoux, the amygdala system has a number of attributes that distinguish it from the hippocampal system and higher cortexes.

- *The amygdala system is unconscious.* Emotional reactions can be formed in the amygdala without any conscious registration of the stimuli. As Zajonc (1984) claimed over a decade ago, emotions can exist without cognitions.<sup>3</sup>

- *The amygdala system is faster.* A danger signal goes via the thalamus to both the amygdala and the cortex. However, the signal reaches the amygdala more rapidly than it reaches the cortex. By the time the cortex has recognized the danger signal, the amygdala has already started responding to the danger. As Zajonc (1984) also claimed, emotions can exist before cognitions.

- *The amygdala system is automatic.* Once the amygdala system makes an appraisal of danger, the emotions and bodily responses occur automatically. In contrast, systems involved in cognitive processing are not so closely tied to automatic responses. The distinguishing feature of cognitive processing is flexibility of responding. Once we have cognition, we have choice.

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<sup>3</sup>In contrast to some cognitive scientists, we define the term “cognition” in this section as *conscious* thoughts or images, not as “implicit” cognitions or simple sensory perceptions.

- *Emotional memories in the amygdala system appear to be permanent.* LeDoux writes: “Unconscious fear memories established through the amygdala appear to be indelibly burned into the brain. They are probably with us for life” (p. 252). There is survival value in never forgetting dangerous stimuli. These memories are resistant to extinction. Under stress, even fears that appear to be extinguished often spontaneously recur. Extinction prevents the expression of conditioned fear responses but does not erase the memories that underlie the responses. “Extinction . . . involves the cortical control over the amygdala’s output rather than a wiping clean of the amygdala’s memory slate” (p. 250). (Thus we say that schemas can probably not be completely healed.)

- *The amygdala system does not make fine discriminations.* The amygdala system is biased toward evoking conditioned fear responses to traumatic stimuli. Once an emotional memory is stored in the amygdala, later exposure to stimuli that even slightly resemble those present during the trauma will unleash the fear reaction. The amygdala system provides a crude image of the external world, whereas the cortex provides more detailed and accurate representations. It is the cortex that is responsible for suppressing responses based on cognitive appraisals. The amygdala evokes responses; it does not inhibit them.

- *The amygdala system is evolutionarily prior to the higher cortexes.* When an individual confronts a threat, the amygdala fires a fear response that has changed very little through the eons and that is shared across the animal kingdom and perhaps even in lower species. The hippocampus is also part of the evolutionarily older part of the brain but is connected to the neocortex, which contains the later developing higher cortexes.

### *Implications for the Schema Model*

Let us consider some possible implications of this research for schema theory. As we have noted, we define an Early Maladaptive Schema as a set of memories, emotions, bodily sensations, and cognitions that revolve around a childhood theme, such as abandonment, abuse, neglect, or rejection. We might conceptualize the brain biology of a schema as follows: Emotions and bodily sensations stored in the amygdala system bear all the attributes previously listed. When an individual encounters stimuli reminiscent of the childhood events that led to the development of the schema, the emotions and bodily sensations associated with the event are activated by the amygdala system unconsciously; or, if the individual is conscious of them, the emotions and bodily sensations are activated more rapidly than the cognitions. This activation of emotions and bodily sensations is automatic and is likely to be a permanent feature of the individual’s life, although the degree of activation might lessen with schema healing. In contrast, conscious memories and cognitions associated with the trauma are stored in the hippocampal system and higher cortexes.

The fact that the emotional and cognitive aspects of traumatic experience are located in different brain systems may explain why schemas are not changeable by simple cognitive methods. In a related point, the cognitive components of a schema often develop later, after the emotions and bodily sensations are already stored in the amygdala system. Many schemas develop in a preverbal stage: They originate before the child has acquired language. Preverbal schemas come into being when the child is so young that all that is stored are the memories, emotions, and bodily sensations. The cognitions are added later, as the child begins to think and speak in words. (This is one of the therapist's roles: to help the patient attach words to the experience of the schema.) Thus emotions have primacy over cognitions in working with many schemas.

When an Early Maladaptive Schema is triggered, the individual is flooded with emotions and bodily sensations. The individual may or may not consciously connect this experience to the original memory. (This is another of the therapist's roles: to help patients connect the emotions and bodily sensations to childhood memories.) The memories are at the heart of a schema, but they are usually not clearly in awareness, even in the form of images. The therapist provides emotional support as the patient struggles to reconstruct these images.

### *Implications for Schema Therapy*

The first goal of schema therapy is psychological awareness. The therapist helps patients identify their schemas and become aware of the childhood memories, emotions, bodily sensations, cognitions, and coping styles associated with them. Once patients understand their schemas and coping styles, they can then begin to exert some control over their responses. They can increase the exercise of their free will in regard to their schemas. LeDoux says:

Therapy is just another way of creating synaptic potentiation in brain pathways that control the amygdala. The amygdala's emotional memories, as we've seen, are indelibly burned into its circuits. The best we can hope to do is to regulate their expression. And the way we do this is by getting the cortex to control the amygdala. (p. 265)

In this light, the goal of treatment is to increase conscious control over schemas, working to weaken the memories, emotions, bodily sensations, cognitions, and behaviors associated with them.

Early childhood trauma affects other parts of the body. Primates separated from their mothers experience elevated plasma cortisol levels. If the separations are repeated, these changes become permanent (Coe, Mendoza, Smotherman, & Levine, 1978; Coe, Glass, Wiener, & Levine, 1983). Other long-lasting neurobiological changes that result from early

separation from the mother include changes in adrenal gland catecholamine synthesizing enzymes (Coe et al., 1978, 1983); and hypothalamic serotonin secretion (Coe, Wiener, Rosenberg, & Levine, 1985). Primate research also suggests that the opioid system is involved in the regulation of separation anxiety and that social isolation affects the sensitivity and number of brain opiate receptors (van der Kolk, 1987). Evidently, early separation experiences result in physical changes that affect psychological functioning and that might well be lifelong.

## SCHEMA OPERATIONS

The two fundamental schema operations are schema perpetuation and schema healing. Every thought, feeling, behavior, and life experience relevant to a schema can be said to either *perpetuate* the schema—elaborating and reinforcing it—or *heal* the schema—thus weakening it.

### Schema Perpetuation

Schema perpetuation refers to everything the patient does (internally and behaviorally) that keeps the schema going. Perpetuation includes all the thoughts, feelings, and behaviors that end up reinforcing rather than healing the schema—all the individual's self-fulfilling prophecies. Schemas are perpetuated through three primary mechanisms: cognitive distortions, self-defeating life patterns, and schema coping styles (which are discussed in detail in the following section). Through cognitive distortions, the individual misperceives situations in such a manner that the schema is reinforced, accentuating information that confirms the schema and minimizing or denying information that contradicts the schema. Affectively, an individual may block the emotions connected to a schema. When affect is blocked, the schema does not reach the level of conscious awareness, so the individual cannot take steps to change or heal the schema. Behaviorally, the individual engages in self-defeating patterns, unconsciously selecting and remaining in situations and relationships that trigger and perpetuate the schema, while avoiding relationships that are likely to heal the schema. Interpersonally, patients relate in ways that prompt others to respond negatively, thus reinforcing the schema.

### Case Illustration

Martine has a Defectiveness schema, stemming mostly from her childhood relationship with her mother. "There was nothing my mother loved about me," she tells her therapist, "and there was nothing I could do about it. I wasn't pretty, I wasn't outgoing and popular, I didn't have a lot of personal-

ity, I didn't know how to dress with a lot of style. The one thing I had, which was that I was smart, didn't mean anything to my mother."

Now Martine is 31 years old. She has few female friends. Recently her boyfriend, Johnny, introduced her to the women who were dating his friends. Martine likes these women very much, but, although they have been welcoming toward her, she feels unable to establish friendships with them. "I don't think they like me," she explains to her therapist. "I get really nervous when I'm with them. I can't settle down and relate normally."

Cognitively, affectively, behaviorally, and interpersonally, Martine acts to perpetuate her schema with these women. Cognitively, she distorts information so that it upholds the schema. She discounts the many gestures of friendliness the women have made toward her ("They're only being nice because of Johnny. They don't really like me.") and falsely interprets things they do and say as evidence of their dislike. For example, when one of the women, Robin, did not ask Martine to be a bridesmaid in her upcoming wedding, Martine jumped to the conclusion that Robin "hated" her, even though she had known Robin for too short a time to be a likely candidate for bridesmaid. Affectively, Martine has strong emotional responses to events that even slightly resemble her childhood schema triggers; she feels intensely upset at any perceived rejection, no matter how slight. When Robin did not ask her to be a bridesmaid, for example, Martine felt utterly worthless and ashamed. "I hate myself," she told her therapist.

Martine gravitates toward relationships that are likely to repeat her childhood relationship with her mother. In the group of women, Martine has most actively sought the friendship of the one who is most hard to please and critical, and, just as she did with her mother as a child, Martine behaves deferentially and apologetically toward her.

Almost all patients who have characterological disorders repeat negative patterns from their childhoods in self-defeating ways. Chronically and pervasively, they engage in thoughts, emotions, behaviors, and means of relating that perpetuate their schemas. In so doing, they unwittingly keep recreating in their adult lives the conditions that most damaged them in childhood.

## Schema Healing

Schema healing is the ultimate goal of schema therapy. Because a schema is a set of memories, emotions, bodily sensations, and cognitions, schema healing involves diminishing all of these: the intensity of the memories connected to the schema, the schema's emotional charge, the strength of the bodily sensations, and the maladaptive cognitions. Schema healing also involves behavior change, as patients learn to replace maladaptive

coping styles with adaptive patterns of behavior. Treatment thus includes cognitive, affective, and behavioral interventions. As a schema heals, it becomes increasingly more difficult to activate. When it is activated, the experience is less overwhelming, and the patient recovers more quickly.

The course of schema healing is often arduous and long. Schemas are hard to change. They are deeply entrenched beliefs about the self and the world, learned at a very young age. They are often all the patient knows. Destructive though they might be, schemas provide patients with feelings of security and predictability. Patients resist giving up schemas because the schemas are central to their sense of identity. It is disrupting to give up a schema. The whole world tilts. In this light, resistance to therapy is a form of self-preservation, an attempt to hold onto a sense of control and inner coherence. To give up a schema is to relinquish knowledge of who one is and what the world is like.

Schema healing requires willingness to face the schema and do battle with it. It demands discipline and frequent practice. Patients must systematically observe the schema and work every day to change. Unless it is corrected, the schema will perpetuate itself. Therapy is like waging war on the schema. The therapist and patient form an alliance in order to defeat the schema, with the goal of vanquishing it. This goal is usually an unrealizable ideal, however: Most schemas never completely heal, because we cannot eradicate the memories associated with them.

Schemas never disappear altogether. Rather, when they heal, they become activated less frequently, and the associated affect becomes less intense and does not last as long. Patients respond to the triggering of their schemas in a healthy manner. They select more loving partners and friends, and they view themselves in more positive ways. We give an overview of how we go about healing schemas in a later section of this chapter.

### MALADAPTIVE COPING STYLES AND RESPONSES

Patients develop maladaptive coping styles and responses early in life in order to adapt to schemas, so that they do not have to experience the intense, overwhelming emotions that schemas usually engender. It is important to remember, however, that, although coping styles sometimes help the patient to avoid a schema, they do not heal it. Thus all maladaptive coping styles still serve as elements in the schema perpetuation process.

Schema therapy differentiates between the schema itself and the strategies an individual utilizes to cope with the schema. Thus, in our model, the schema itself contains memories, emotions, bodily sensations, and cognitions, but not the individual's behavioral responses. *Behavior is not part of the schema; it is part of the coping response.* The schema drives the

behavior. Although the majority of coping responses are behavioral, patients also cope through cognitive and emotive strategies. Whether the coping style is manifested through cognition, affect, or behavior, it is not part of the schema itself.

The reason that we differentiate schemas from coping styles is that each patient utilizes different coping styles in different situations at different stages of their lives to cope with the same schema. Thus the coping styles for a given schema do not necessarily remain stable for an individual over time, whereas the schema itself does. Furthermore, different patients use widely varying, even opposite, behaviors to cope with the same schema.

For example, consider three patients who typically cope with their Defectiveness schemas through different mechanisms. Although all three feel flawed, one seeks out critical partners and friends, one avoids getting close to anyone, and one adopts a critical and superior attitude toward others. Thus the coping behavior is not intrinsic to the schema.

### Three Maladaptive Coping Styles

All organisms have three basic responses to threat: fight, flight, and freeze. These correspond to the three schema coping styles of *overcompensation*, *avoidance*, and *surrender*. In very broad terms, fight is overcompensation, flight is avoidance, and freeze is surrender.

In the context of childhood, an Early Maladaptive Schema represents the presence of a threat. The threat is the frustration of one of the child's core emotional needs (for secure attachment, autonomy, free self-expression, spontaneity and play, or realistic limits). The threat may also include the fear of the intense emotions the schema unleashes. Faced with the threat, the child can respond through some combination of these three coping responses: the child can surrender, avoid, or overcompensate. All three coping styles generally operate out of awareness—that is, unconsciously. In any given situation, the child will probably utilize only one of them, but the child can exhibit different coping styles in different situations or with different schemas. (We provide examples of these three styles below.)

Thus the triggering of a schema is a threat—the frustration of a core emotional need and the concomitant emotions—to which the individual responds with a coping style. These coping styles are usually adaptive in childhood and can be viewed as healthy survival mechanisms. But they become maladaptive as the child grows older because the coping styles continue to perpetuate the schema, even when conditions change and the individual has more promising options. Maladaptive coping styles ultimately keep patients imprisoned in their schemas.

### *Schema Surrender*

When patients surrender to a schema, they yield to it. They do not try to avoid it or fight it. They accept that the schema is true. They feel the emotional pain of the schema directly. They act in ways that confirm the schema. Without realizing what they are doing, they repeat schema-driven patterns so that, as adults, they continue to relive the childhood experiences that created the schema. When they encounter schema triggers, their emotional responses are disproportionate, and they experience their emotions fully and consciously. Behaviorally, they choose partners who are most likely to treat them as the “offending parent” did—as Natalie, the depressed patient we described earlier, chose her emotionally depriving husband Paul. They then frequently relate to these partners in passive, compliant ways that perpetuate the schema. In the therapy relationship, these patients also may play out the schema with themselves in the “child” role and the therapist in the role of the “offending parent.”

### *Schema Avoidance*

When patients utilize avoidance as a coping style, they try to arrange their lives so that the schema is never activated. They attempt to live without awareness, as though the schema does not exist. They avoid thinking about the schema. They block thoughts and images that are likely to trigger it: When such thoughts or images loom, they distract themselves or put them out of their minds. They avoid feeling the schema. When feelings surface, they reflexively push them back down. They may drink excessively, take drugs, have promiscuous sex, overeat, compulsively clean, seek stimulation, or become workaholics. When they interact with others, they may appear perfectly normal. They usually avoid situations that might trigger the schema, such as intimate relationships or work challenges. Many patients shun whole areas of life in which they feel vulnerable. Often they avoid engaging in therapy; for example, these patients might “forget” to complete homework assignments, refrain from expressing affect, raise only superficial issues, come late to sessions, or terminate prematurely.

### *Schema Overcompensation*

When patients overcompensate, they fight the schema by thinking, feeling, behaving, and relating as though the opposite of the schema were true. They endeavor to be as different as possible from the children they were when the schema was acquired. If they felt worthless as children, then as adults they try to be perfect. If they were subjugated as children, then as adults they defy everyone. If they were controlled as children, as adults they control others or reject all forms of influence. If abused, they abuse

others. Faced with the schema, they counterattack. On the surface, they are self-confident and assured, but underneath they feel the press of the schema threatening to erupt.

Overcompensation can be viewed as a partially healthy attempt to fight back against the schema that unfortunately overshoots the mark, so that the schema is perpetuated rather than healed. Many “overcompensators” appear healthy. In fact, some of the most admired people in society—media stars, political leaders, business tycoons—are often overcompensators. It is healthy to fight back against a schema so long as the behavior is proportionate to the situation, takes into account the feelings of others, and can reasonably be expected to lead to a desirable outcome. But overcompensators typically get locked into counterattacking. Their behavior is usually excessive, insensitive, or unproductive.

For example, it is healthy for subjugated patients to exert more control in their lives; but, when they overcompensate, they become *too* controlling and domineering and end up driving others away. An overcompensated patient with subjugation cannot allow others to take the lead, even when it would be healthy to do so. Similarly, it is healthy for an emotionally deprived patient to ask others for emotional support, but an overcompensated patient with emotional deprivation goes too far and becomes demanding and feels entitled.

Overcompensation develops because it offers an alternative to the pain of the schema. It is a means of escape from the sense of helplessness and vulnerability that the patient felt growing up. For example, narcissistic overcompensations typically serve to help patients cope with core feelings of emotional deprivation and defectiveness. Rather than feeling ignored and inferior, these patients can feel special and superior. However, though they may be successful in the outside world, narcissistic patients are usually not at peace within themselves. Their overcompensation isolates them and ultimately brings them unhappiness. They continue to overcompensate, no matter how much it drives away other people. In so doing, they lose the ability to connect deeply with others. They are so invested in appearing to be perfect that they forfeit true intimacy. Further, no matter how perfect they try to be, they are bound to fail at something eventually, and they rarely know how to handle defeat constructively. They are unable to take responsibility for their failures or acknowledge their limitations and therefore have trouble learning from their mistakes. When they experience sufficiently powerful setbacks, their ability to overcompensate collapses, and they often decompensate by becoming clinically depressed. When overcompensation fails, the underlying schemas reassert themselves with enormous emotional strength.

We hypothesize that temperament is one of the main factors in determining why individuals develop certain coping styles rather than others. In fact, temperament probably plays a greater role in determining patients’

coping styles than it does in determining their schemas. For example, individuals who have passive temperaments are probably more likely to surrender or avoid, whereas individuals who have aggressive temperaments are more likely to overcompensate. Another factor in explaining why patients adopt a given coping style is selective internalization, or modeling. Children often model the coping behavior of a parent with whom they identify.

We elaborate further on these coping styles in Chapter 5.

### Coping Responses

Coping *responses* are the *specific* behaviors or strategies through which the three broad coping styles are expressed. They include all the responses to threat in the individual's behavioral repertoire—all the unique, idiosyncratic ways in which patients manifest overcompensation, avoidance, and surrender. When the individual habitually adopts certain coping responses, then coping responses adhere into “coping styles.” Thus a coping style is a trait, whereas a coping response is a state. A coping style is a collection of coping responses that an individual characteristically utilizes to avoid, surrender, or overcompensate. A coping response is the specific behavior (or strategy) that the individual is exhibiting at a given point in time. For example, consider a male patient who uses some form of avoidance in almost any situation in which his schema of abandonment is triggered. When his girlfriend threatened to break up with him, he went back to his apartment and drank beer until he passed out. In this example, avoidance is the patient's coping *style* for abandonment; drinking beer was his coping *response* in this one situation with his girlfriend. (We discuss this distinction further in the following section on schema modes.)

Table 1.1 lists some examples of maladaptive coping responses for each schema. Most patients use a combination of coping responses and styles. Sometimes they surrender, sometimes they avoid, and sometimes they overcompensate.

### Schemas, Coping Responses, and Axis II Diagnoses

We believe that the Axis II diagnostic system in DSM-IV is seriously flawed. Elsewhere (Young & Gluhoski, 1996) we have reviewed its many limitations, including low reliability and validity for many categories and the unacceptable level of overlap among the categories. In this chapter, however, we emphasize what we see as more fundamental conceptual flaws in the Axis II system. We believe that in an attempt to establish criteria based on observable behaviors, the developers have lost the essence of both what distinguishes Axis I from Axis II disorders and what makes chronic disorders hard to treat.

According to our model, internal schemas lie at the core of personality disorders and the behavioral patterns in DSM-IV are primarily responses to the core schemas. As we have stressed, healing schemas should be the central goal in working with patients at a characterological level. Eliminating maladaptive coping responses permanently is almost impossible without changing the schemas that drive them. Also, because the coping behaviors are not as stable as schemas—they change depending on the schema, the life situation, and the patient's stage of life—the patient's symptoms (and diagnosis) will appear to be shifting as one tries to change them.

For most DSM-IV categories, the coping behaviors *are* the personality disorders. Many diagnostic criteria are lists of coping responses. In contrast, the schema model accounts for chronic, pervasive characterological patterns in terms of both schemas and coping responses; it relates the schemas and coping responses to their origins in early childhood; and it provides direct and clear implications for treatment. Furthermore, each patient is viewed as having a unique profile, including several schemas and coping responses, each present at different levels of strength (dimensional) rather than as one single Axis II category.

## SCHEMA MODES

The concept of a schema mode is probably the most difficult part of schema theory to explain, because it encompasses many elements. Schema modes are the moment-to-moment emotional states and coping responses—adaptive and maladaptive—that we all experience. Often our schema modes are triggered by life situations to which we are oversensitive (our “emotional buttons”). Unlike most other schema constructs, we are actively interested in working with both adaptive and maladaptive modes. In fact, we try to help patients flip from a dysfunctional mode to a healthy mode as part of the schema healing process.

At any given point in time, some of our schemas or schema operations (including our coping responses) are inactive, or dormant, while others have become activated by life events and predominate in our current moods and behavior. The predominant state that we are in at a given point in time is called our “schema mode.” We use the term “flip” to refer to the switching of modes. As we have said, this state may be adaptive or maladaptive. All of us flip from mode to mode over time. A mode, therefore, answers the question, “At this moment in time, what set of schemas or schema operations is the patient manifesting?”

Our revised definition of a schema mode is: “those schemas or schema operations—adaptive or maladaptive—that are currently active for an individual.” A *dysfunctional* schema mode is activated when specific maladaptive schemas or coping responses have erupted into distressing emo-

TABLE 1.1. Examples of Maladaptive Coping Responses

Early Maladaptive Schema	Examples of surrender	Examples of avoidance	Examples of overcompensation
Abandonment/Instability	Selects partners who cannot make a commitment and remains in the relationships	Avoids intimate relationships; drinks a lot when alone	Clings to and "smothers" the partner to point of pushing partner away; vehemently attacks partner for even minor separations
Mistrust/Abuse	Selects abusive partners and permits abuse	Avoids becoming vulnerable and trusting anyone; keeps secrets	Uses and abuses others ("get others before they get you")
Emotional Deprivation	Selects emotionally depriving partners and does not ask them to meet needs	Avoids intimate relationships altogether	Acts emotionally demanding with partners and close friends
Defectiveness/Shame	Selects critical and rejecting friends; puts self down	Avoids expressing true thoughts and feelings and letting others get close	Criticizes and rejects others while seeming to be perfect.
Social Isolation/Alienation	At social gatherings, focuses exclusively on differences from others rather than similarities	Avoids social situations and groups	Becomes a chameleon to fit into groups
Dependence/Incompetence	Asks significant others (parents, spouse) to make all his or her financial decisions	Avoids taking on new challenges, such as learning to drive	Becomes so self-reliant that he or she does not ask anyone for anything ("counterdependent")
Vulnerability to Harm or Illness	Obsessively reads about catastrophes in newspapers and anticipates them in everyday situations	Avoids going places that do not seem totally "safe"	Acts recklessly, without regard to danger ("counterphobic")
Enmeshment/Undeveloped Self	Tells mother everything, even as an adult; lives through partner	Avoids intimacy; stays independent	Tries to become the opposite of significant others in all ways
Failure	Does tasks in a halfhearted or haphazard manner	Avoids work challenges completely; procrastinates on tasks	Becomes an "overachiever" by ceaselessly driving him- or herself

(cont.)

TABLE 1.1. (cont.)

Early Maladaptive Schema	Examples of surrender	Examples of avoidance	Examples of overcompensation
Entitlement/ Grandiosity	Bullies others into getting own way, brags about own accomplishments	Avoids situations in which he or she is average, not superior	Attends excessively to the needs of others
Insufficient Self-Control/Self-Discipline	Gives up easily on routine tasks	Avoids employment or accepting responsibility	Becomes overly self-controlled or self-disciplined
Subjugation	Lets other individuals control situations and make choices	Avoids situations that might involve conflict with another individual	Rebels against authority
Self-Sacrifice	Gives a lot to others and asks for nothing in return	Avoids situations involving giving or taking	Gives as little to others as possible
Approval-Seeking/ Recognition-Seeking	Acts to impress others	Avoids interacting with those whose approval is coveted	Goes out of the way to provoke the disapproval of others; stays in the background
Negativity/ Pessimism	Focuses on the negative; ignores the positive; worries constantly; goes to great lengths to avoid any possible negative outcome	Drinks to blot out pessimistic feelings and unhappiness	Is overly optimistic (“Pollyanna”-ish); denies unpleasant realities
Emotional Inhibition	Maintains a calm, emotionally flat demeanor	Avoids situations in which people discuss or express feelings	Awkwardly tries to be the “life of the party,” even though it feels forced and unnatural
Unrelenting Standards/ Hypercriticalness	Spends inordinate amounts of time trying to be perfect	Avoids or procrastinates in situations and tasks in which performance will be judged	Does not care about standards at all—does tasks in a hasty, careless manner
Punitiveness	Treats self and others in harsh, punitive manner	Avoids others for fear of punishment	Behaves in overly forgiving way

tions, avoidance responses, or self-defeating behaviors that take over and control an individual's functioning. An individual may shift from one dysfunctional schema mode into another; as that shift occurs, different schemas or coping responses, previously dormant, become active.

### Dysfunctional Schema Modes as Dissociated States

Viewed in a different way, a dysfunctional schema mode is a facet of the self involving specific schemas or schema operations that has not been fully integrated with other facets. According to this perspective, schema modes can be characterized by the degree to which a particular schema-driven state has become dissociated, or cut off, from an individual's other modes. A dysfunctional schema mode, therefore, is a part of the self that is cut off to some degree from other aspects of the self.

A dysfunctional schema mode can be described in terms of the point on a *spectrum* of dissociation at which this particular mode lies. To the degree that an individual is simultaneously able to experience or blend more than one mode, the level of dissociation is lower. We typically refer to this mild form of a schema mode as a normal mood shift, such as a lonely mood or an angry mood. At the highest level of dissociation is a patient with dissociative identity disorder (or multiple personality disorder). In these instances, a patient in one mode may not even know that another mode exists; and, in extreme cases, a patient with dissociative identity disorder (DID) may even have a different name for each mode. We discuss this concept of modes as dissociative states in more depth later.

We have currently identified 10 schema modes, although more modes will undoubtedly be identified in the future. The modes are grouped into four general categories: Child modes, Dysfunctional Coping modes, Dysfunctional Parent modes, and the Healthy Adult mode. Some modes are healthy for an individual, whereas others are maladaptive. We elaborate further on these 10 modes in a subsequent section.

One important goal of schema therapy is to teach patients how to strengthen their Healthy Adult modes, so that they can learn to navigate, negotiate with, nurture, or neutralize dysfunctional modes.

### The Development of the Mode Concept

The concept of schema modes originated from our work with patients with borderline personality disorder (BPD), although now we apply it to many other diagnostic categories as well. One of the problems we were having applying the schema model to patients with BPD was that the number of schemas and coping responses they had was overwhelming for both the patient and the therapist to deal with all at one time. For example, we

find that, when we give patients with BPD the Young Schema Questionnaire, it is not unusual for them to score high on almost all of the 16 schemas assessed. We found that we needed a different unit of analysis, one that would group schemas together and make them more manageable.

Patients with BPD were also problematic for the original schema model because they continually shift from one extreme affective state or coping response to another: One moment they are angry; the next they may be sad, detached, avoidant, robotic, terrified, impulsive, or filled with self-hatred. Our original model, because it focused primarily on trait constructs—a schema or a coping style—did not seem sufficient to account for the phenomenon of shifting states.

Let us elaborate further on this state–trait distinction as it relates to schema theory. When we say that an individual has a schema, we are not saying that at every moment the schema is activated. Rather, the schema is a trait that may or may not be activated at a given moment. Similarly, individuals have characteristic coping styles, which they may or may not be utilizing at a given moment. Thus our original trait model tells us about the functioning of the patient over time, but it does not tell us about the patient's current state. Because patients with BPD are so labile, we decided to move away from a trait model and toward a state model in treating them, with the schema mode as the primary conceptual construct.

When we look carefully at individual patients, we observe that their schemas and coping responses tend to group together into parts of the self. Certain clusters of schemas or coping responses are triggered together. For example, in the Vulnerable Child mode, the affect is that of a helpless child—fragile, frightened, and sad. When a patient is in this mode, schemas of Emotional Deprivation, Abandonment, and Vulnerability may be simultaneously activated. The Angry Child mode often presents with the affect of an enraged child having a temper tantrum. The Detached Protector mode is characterized by the absence of emotion, combined with high levels of avoidance. Thus some of the modes are composed primarily of schemas, whereas others primarily represent coping responses.

Each individual patient exhibits certain characteristic schema modes, by which we mean characteristic groupings of schemas or coping responses. Similarly, some Axis II diagnoses can be described in terms of their typical modes. For example, the patient with BPD usually exhibits four schema modes and shifts rapidly from one to the other. One moment the patient is in the Abandoned Child mode, experiencing the pain of her schemas; the next moment she may flip into the Angry Child mode, expressing rage; she may then shift into the Punitive Parent mode, punishing the Abandoned Child; and finally she may retreat into the Detached Protector, blocking her emotions and detaching from people to protect herself.

### Modes as Dissociated States

We mentioned briefly that our concept of a schema mode relates to a spectrum of dissociation. Although we realize that the diagnosis has become controversial, we view the different personalities of patients with DID as extreme forms of dysfunctional modes. Different parts of the self have split off into separate personalities that are often unaware of each other and that may have different names, ages, genders, personality traits, memories, and functions. The dissociative identities of these patients usually consist of either a child at a specific age who has experienced severe trauma; an internalized parent tormenting, criticizing, or persecuting the child; or an adult-like coping mode that in some way protects or blocks out the child modes. We believe that the dissociative identities in DID differ from the modes of patients with BPD mainly in degree and number. Both multiple personalities and borderline modes are parts of the self that have been split off, but the borderline modes have not been split off to nearly the same degree. Furthermore, patients with DID usually have more modes than patients with BPD because they frequently have more than one mode of each type (e.g., three Vulnerable Child modes, each a different age).

A psychologically healthy individual still has recognizable modes, but the sense of a unified identify remains intact. A healthy individual might shift into a detached, angry, or sad mood in response to changing circumstances, but these modes will differ from borderline modes in several important respects. First, as we have said, normal modes are less dissociated than borderline modes. Healthy individuals can experience more than one mode simultaneously. For example, they can be both sad and happy about an event, thus producing the sensation of “bittersweet.” In contrast, when we talk about a borderline mode, we are referring to one part of the self that is split off from the other parts in a pure and intense form. The individual is overwhelmingly frightened or completely enraged. Second, normal modes are less rigid and more flexible and open to change than the modes of patients with serious characterological problems. In Piagetian terms, they are more open to accommodation in response to reality (Piaget, 1962).

To summarize, modes vary from one individual to another along several dimensions:

Dissociated ↔ Integrated  
 Unacknowledged ↔ Acknowledged  
 Maladaptive ↔ Adaptive  
 Extreme ↔ Mild  
 Rigid ↔ Flexible  
 Pure ↔ Blended

Another difference between healthy and more impaired individuals lies in the strength and effectiveness of the Healthy Adult mode. Although we all have a Healthy Adult mode, the mode is stronger and more frequently activated in psychologically healthy people. The Healthy Adult mode can moderate and heal dysfunctional modes. For example, when psychologically healthy people become angry, they have a Healthy Adult mode that can usually keep angry emotions and behaviors from going out of control. In contrast, patients with BPD typically have a very weak Healthy Adult mode, so that when the Angry Child mode is triggered, there is no strong counterbalancing force. The anger almost completely takes over the patient's personality.

## 10 Schema Modes

We have identified 10 schema modes that can be grouped into four broad categories: Child modes, Dysfunctional Coping modes, Dysfunctional Parent modes, and the Healthy Adult mode.

We believe that the Child modes are innate and universal. All children are born with the potential to manifest them. We have identified four: the Vulnerable Child, the Angry Child, the Impulsive/Undisciplined Child, and the Happy Child modes. (These labels are general terms. In actual therapy we individualize the names of modes collaboratively with patients. For example, we might refer to the Vulnerable Child mode as Little Ann, or Abandoned Carol.)

The Vulnerable Child is the mode that usually experiences most of the core schemas: It is the Abandoned Child, the Abused Child, the Deprived Child, or the Rejected Child. The Angry Child is the part that is enraged about unmet emotional needs and that acts in anger without regard to consequences. The Impulsive/Undisciplined Child expresses emotions, acts on desires, and follows natural inclinations from moment to moment in a reckless manner, without regard to possible consequences for the self or others. The Happy Child is one whose core emotional needs are currently met.

We have identified three dysfunctional coping modes: the Compliant Surrenderer, the Detached Protector, and the Overcompensator. These three modes correspond to the three coping styles of surrender, avoidance, and overcompensation. (Again, we tailor the name of the mode so that it fits the feelings and behaviors of the individual patient.) The Compliant Surrenderer submits to the schema, becoming once again the passive, helpless child who must give in to others. The Detached Protector withdraws psychologically from the pain of the schema by emotionally detaching, abusing substances, self-stimulating, avoiding people, or utilizing other forms of escape. The Overcompensator fights back either by mistreating others or by behaving in extreme ways in an

attempt to disprove the schema in a manner that ultimately proves dysfunctional (see the previous discussion of overcompensation for examples). All three maladaptive coping modes ultimately perpetuate schemas.

We have identified two dysfunctional parent modes thus far: the Punitive Parent and the Demanding Parent. In these modes, the patient becomes like the parent who has been internalized. The Punitive Parent punishes one of the child modes for being “bad,” and the Demanding Parent continually pushes and pressures the child to meet excessively high standards.

The 10th mode, as described earlier, is the Healthy Adult. This is the mode we try to strengthen in therapy by teaching the patient to moderate, nurture, or heal the other modes.

## SCHEMA ASSESSMENT AND CHANGE

This brief overview of the treatment process presents the steps in assessing and changing schemas. Each of these procedures is described in detail in later chapters. The two phases of treatment are the Assessment and Education Phase and the Change Phase.

### Assessment and Education Phase

In this first phase, the schema therapist helps patients to identify their schemas and to understand the origins of the schemas in childhood and adolescence. In the course of the assessment, the therapist educates the patient about the schema model. Patients learn to recognize their maladaptive coping styles (surrender, avoidance, and overcompensation) and to see how their coping responses serve to perpetuate their schemas. We also teach more severely impaired patients about their primary schema modes and help them observe how they flip from one mode to another. We want patients both to understand their schema operations intellectually and to experience these processes emotionally.

The assessment is multifaceted, including a life history interview, several schema questionnaires, self-monitoring assignments, and imagery exercises that trigger schemas emotionally and help patients make emotional links between current problems and related childhood experiences. By the end of this phase, the therapist and patient have developed a complete schema case conceptualization and have agreed on a schema-focused treatment plan that encompasses cognitive, experiential, and behavioral strategies, as well as the healing components of the therapist–patient relationship.

## Change Phase

Throughout the Change Phase, the therapist blends cognitive, experiential, behavioral, and interpersonal strategies in a flexible manner, depending on the needs of the patient week by week. The schema therapist does not adhere to a rigid protocol or set of procedures.

### *Cognitive Techniques*

As long as patients believe that their schemas are valid, they will not be able to change; they will continue to maintain distorted views of themselves and others. Patients learn to build a case against the schema. They disprove the validity of the schema on a rational level. Patients list all the evidence supporting and refuting the schema throughout their lives, and the therapist and patient evaluate the evidence.

In most cases, the evidence will show that the schema is false. The patient is not inherently defective, incompetent, or a failure. Rather, through a process of indoctrination, the schema was taught to the patient in childhood, much as propaganda is taught to the populace. But sometimes the evidence alone is not sufficient to disprove the schema. For example, patients might in fact be failures at work or at school. As a result of procrastination and avoidance, they have not developed the relevant work skills. If there is not enough existing evidence to challenge the schema, then patients evaluate what they can do to change this aspect of their lives. For example, the therapist can guide them to fight expectations of failure so they can learn effective work skills.

After this exercise, the therapist and patient summarize the case against the schema on a flash card that they compose together. Patients carry these flash cards with them and read them frequently, especially when they are facing schema triggers.

### *Experiential Techniques*

Patients fight the schema on an emotional level. Using such experiential techniques as imagery and dialogues, they express anger and sadness about what happened to them as children. In imagery, they stand up to the parent and other significant childhood figures, and they protect and comfort the vulnerable child. Patients talk about what they needed but did not receive from the parents when they were children. They link childhood images with images of upsetting situations in their current lives. They confront the schema and its message directly, opposing the schema and fighting back. Patients practice talking back to significant people in their current lives through imagery and role-playing. This em-

powers patients to break the schema perpetuation cycle at an emotional level.

### *Behavioral Pattern-Breaking*

The therapist helps the patient design behavioral homework assignments in order to replace maladaptive coping responses with new, more adaptive patterns of behavior. The patient comes to see how certain partner choices or life decisions perpetuate the schema, and begins to make healthier choices that break old self-defeating life patterns.

The therapist helps the patient plan and prepare for homework assignments by rehearsing new behaviors in imagery and role-playing in the session. The therapist uses flash cards and imagery techniques to help the patient overcome obstacles to behavioral change. After carrying out assignments, the patient discusses the results with the therapist, evaluating what was learned. The patient gradually gives up maladaptive coping styles in favor of more adaptive patterns.

Most of these dysfunctional behaviors are, in fact, coping responses to schemas, and they are often the main obstacles to schema healing. Patients must be willing to give up their maladaptive coping styles in order to change. For example, patients who continue surrendering to the schema—by remaining in destructive relationships or by not setting limits in their personal or work lives—perpetuate the schema and are not able to make significant progress in therapy. Overcompensators may fail to make progress in treatment because, rather than acknowledging their schemas and taking responsibility for their problems, they blame others. Or they may be too preoccupied with overcompensating—by working harder, improving themselves, impressing others—to clearly identify their schemas and apply themselves to changing.

Avoiders may fail to progress because they keep escaping from the pain of their schemas. They do not allow themselves to focus on their problems, their pasts, their families, or their life patterns. They cut off their emotions or dull them. It takes motivation to overcome avoidance as a coping style. Because avoidance is rewarding in the short run, patients must be willing to endure discomfort and to continually confront themselves with the long-term negative consequences.

### *The Therapist–Patient Relationship*

The therapist assesses and treats schemas, coping styles, and modes as they arise in the therapeutic relationship. The therapist–patient relationship serves as a partial antidote to the patient's schemas. The patient internalizes the therapist as a “Healthy Adult” who fights against schemas and pursues an emotionally fulfilling life.

Two features of the therapy relationship are especially important elements of schema therapy: the therapeutic stance of *empathic confrontation* and the use of *limited reparenting*. Empathic confrontation involves showing empathy for the patients' schemas when they arise toward the therapist, while showing patients that their reactions to the therapist are often distorted or dysfunctional in ways that reflect their schemas and coping styles. Limited reparenting involves supplying, within the appropriate bounds of the therapeutic relationship, what patients needed but did not receive from their parents in childhood. We discuss these concepts at greater length later.

### COMPARISON BETWEEN SCHEMA THERAPY AND OTHER MODELS

In the development of a conceptual and treatment approach, schema therapists adopt a philosophy of openness and inclusion. They cast a wide net, searching for solutions with little concern about whether their work will be classified as cognitive-behavioral, psychodynamic, or Gestalt. The primary focus is on whether patients are changing in significant ways. This attitude has contributed to a sense of freedom for both patients and therapists concerning what they discuss in sessions, which interventions they use, and how they implement these interventions. Moreover, the model readily incorporates the therapist's personal style.

Schema therapy is not, however, an eclectic therapy in the sense of proceeding by trial and error. It is based on a unifying theory. The theory and strategies are tightly woven into a structured, systematic model.

As a result of this inclusive philosophy, the schema model overlaps with many other models of psychopathology and psychotherapy, including cognitive-behavioral, constructivist, psychodynamic, object relations, and Gestalt approaches. Although aspects of schema therapy overlap with these other models, the schema model also differs in important respects. Although schema theory contains concepts similar to those in many psychological schools, no one school overlaps with schema therapy completely.

In this section, we highlight some key similarities and differences between schema therapy and Beck's recent formulations of cognitive therapy. We also touch briefly on some other therapy approaches that overlap in important ways with schema therapy.

#### Beck's "Reformulated" Model

Beck and his associates (Beck et al., 1990; Alford & Beck, 1997) have revised cognitive therapy to treat personality disorders. Personality is de-

defined as “specific patterns of social, motivational and cognitive-affective processes” (Alford & Beck, 1997, p. 25). Personality includes behaviors, thought processes, emotional responses, and motivational needs.

Personality is determined by the “idiosyncratic structures,” or schemas, that constitute the basic elements of personality. Alford and Beck (1997) propose that the schema concept may “provide a common language to facilitate the integration of certain psychotherapeutic approaches” (p. 25). According to Beck’s model, a “core belief” represents the meaning, or cognitive content, of a schema.

Beck has also elaborated his own concept of a *mode* (Beck, 1996). A mode is an integrated network of cognitive, affective, motivational, and behavioral components. A mode may comprise many cognitive schemas. These modes mobilize individuals in intense psychological reactions, and are oriented toward achieving particular aims. Like schemas, modes are primarily automatic and also require activation. Individuals with a cognitive vulnerability who are exposed to relevant stressors may develop symptoms related to the mode.

According to Beck’s view (Alford & Beck, 1997), modes consist of schemas, which contain memories, problem-solving strategies, images, and language. Modes activate “programmed strategies for carrying out basic categories of survival skills, such as defense from predators” (p. 27). The activation of a specific mode is derived from an individual’s genetic makeup and cultural and social beliefs.

Beck (1996, p. 9) further explains that a corresponding mode is not necessarily activated when a schema is triggered. Even though the cognitive component of a schema has been triggered, we may not see any corresponding affective, motivational, or behavioral components.

In treatment, a patient learns to utilize the conscious control system to deactivate modes by reinterpreting trigger events in a manner inconsistent with the mode. Furthermore, modes can be modified.

After an extensive review of the cognitive therapy literature, we conclude that Beck has not elaborated—except in very general terms—on how the techniques for changing schemas and modes are different from those prescribed in standard cognitive therapy. Alford and Beck (1997) acknowledge that the therapeutic relationship is a valid mechanism for change and even that structured imagery work can alter cognitive structures by communicating “directly with the experiential (automatic system) [in its own medium, mainly fantasy]” (p. 70). But we cannot find detailed and distinctive change strategies for schemas or modes.

Finally, Beck et al. (1990) discuss patients’ cognitive and behavioral *strategies*. These strategies seem equivalent to the schema therapy notion of coping styles. Psychologically healthy individuals cope with life situations with adaptive cognitive and behavioral strategies, whereas psycho-

logically impaired people utilize inflexible, maladaptive responses within their vulnerable areas.

Conceptually, Beck's revised cognitive model and Young's latest statement of his schema model presented in this chapter have many points of similarity. Both emphasize two broad central structures—schemas and modes—in understanding personality. Both theories include cognition, motivation, emotion, genetic makeup, coping mechanisms, and cultural influences as important aspects of personality. Both models acknowledge the need to focus on both conscious and unconscious aspects of personality.

The differences between the two theoretical models are subtle and often reflect differences in emphasis, not fundamental areas of disagreements. Young's concept of an Early Maladaptive Schema incorporates elements of both schemas and modes, as defined by Beck (1996). Young defines schema activation as incorporating affective, motivational, and behavioral components. Both the structure and content of schemas that Beck discusses are incorporated into Young's definition of schemas.

Mode activation is very similar to Young's concept of schema activation. It is unclear why Beck (1996) needs to differentiate schemas from modes, based on his definitions of these terms. In our opinion, his mode concept could easily be broadened to encompass the elements of a schema (or vice versa). Perhaps Beck wants to differentiate schemas from modes to emphasize that modes are evolutionary mechanisms for survival. The concept of a schema, in Beck's revised model, remains closer to his original cognitive model (Beck, 1976) and as such is more closely related to other cognitive constructs such as automatic thoughts and core beliefs.

Young's concept of a schema mode is only marginally related to Beck's use of the term "mode." Beck (1996) developed his mode construct to account for intense psychological reactions that are survival related and goal oriented. Young developed his mode concept to differentiate between schemas and coping styles as *traits* (enduring, consistent patterns) and schemas and coping styles as *states* (shifting patterns of activation and deactivation). In this sense, Young's concept of a schema mode is more related to concepts of dissociation and "ego states" than to Beck's mode concept.

Another important conceptual difference is the relative emphasis placed on coping styles. Although Beck et al. (1990) refer to maladaptive coping strategies, Beck did not include them as major constructs in his reformulation (Beck, 1996; Alford & Beck, 1997). Young's model, in contrast, assigns a central role to coping styles in perpetuating schemas. This emphasis and elaboration on schema surrender, avoidance, and overcompensation is in sharp contrast with Beck's limited discussion.

Another major difference is the greater importance placed on core

needs and developmental processes in schema therapy than in cognitive therapy. Although Beck and his associates agree in general that motivational needs and childhood influences play an important role in personality, they do not expand on what the core needs are or on how specific childhood experiences lead to the development of schemas and modes.

Not surprisingly, as Young's primary influence prior to developing schema therapy was Beck's cognitive approach, there are many areas of overlap in the treatments. Both encourage a high degree of collaboration between patient and therapist and advocate that the therapist play an active role in directing sessions and the course of treatment. Young and Beck agree that empiricism plays an important role in cognitive change; therefore, both treatments encourage patients to modify their cognitions—including schemas—to be more in line with "reality," or empirical evidence from the patient's life. The two approaches similarly share many cognitive and behavioral-change techniques, such as keeping track of cognitions and behavioral rehearsal. In both approaches, patients are taught strategies for altering automatic thoughts, underlying assumptions, cognitive distortions, and core beliefs.

Cognitive and schema therapies both emphasize the importance of educating the patient about the respective therapy models. Thus the patient is brought into the therapeutic process as an equal participant. The therapist shares the case conceptualization with the patient and encourages the patient to read self-help material elaborating on each approach. Homework and self-help assignments play a central role in both therapies as a mechanism for assisting patients in generalizing what they learn in the session into their lives outside. Also, to facilitate this transfer of learning, schema and cognitive therapists both teach practical strategies for handling concrete life events outside the session in an adaptive manner, rather than relying on patients to figure out for themselves how to apply general cognitive-behavioral principles.

Despite these similarities, there are also major differences in treatment approach between schema and cognitive therapies. Many of these differences flow from the fact that the treatment techniques of cognitive therapy were originally developed to reduce symptoms of Axis I disorders, whereas schema therapy strategies focused, from the beginning, on personality disorders and lifelong chronic problems. It has been our experience that there are fundamental differences in effective change techniques for symptom reduction compared with personality change.

First, schema therapy begins from the "bottom up" rather than "top down." In other words, schema therapists begin at the core level—schemas—and gradually link these schemas to more accessible cognitions, such as automatic thoughts and cognitive distortions. In contrast, cognitive therapists begin with surface-level cognitions such as automatic

thoughts and address core beliefs later, if the patient remains in treatment once the symptoms have been alleviated.

In schema therapy, this bottom-up approach leads to a dramatic shift in focus early in treatment from present issues to lifelong patterns. Furthermore, in schema therapy, the majority of time is devoted to schemas, coping styles, and modes, whereas these are usually secondary in cognitive therapy. This shift in focus also leads schema therapists to impose less structure and a less formal agenda on sessions. The schema therapist needs the freedom to move fluidly between past and present, from one schema to another, within a session and between sessions. In cognitive therapy, by contrast, clearly identified current problems or sets of symptoms are pursued consistently by the therapist until they have remitted.

Furthermore, because schemas and coping styles are most central to the model, Young has elaborated 18 specific early schemas and three broad coping styles that form the basis for much of the treatment. These schemas and coping mechanisms are assessed and are further refined later in therapy to better fit each individual patient. Thus the schema therapist has valuable tools to help identify schemas and coping behaviors that might otherwise be missed through normal cognitive assessment techniques. An excellent example is the Emotional Deprivation schema, which is relatively easy to uncover using schema-focused imagery, but very difficult to recognize by asking for automatic thoughts or exploring underlying assumptions.

Another important difference is in the emphasis placed on childhood origins and parenting styles in schema therapy. Cognitive therapy lacks specificity about the origins of cognitions, including core beliefs. In contrast, schema therapists have identified the most common origins for each of the 18 schemas, and an instrument has been developed to assess them. The therapist explains these origins to patients to educate them about the normal needs of a child and to explain what happens when these needs are not met and links childhood origins with whichever schemas from the list of 18 are relevant for the patient. In addition to assessing and educating patients about the origins of their schemas, schema therapists guide patients through a variety of experiential exercises related to upsetting childhood experiences. These exercises help patients overcome maladaptive emotions, cognitions, and coping behaviors. In contrast, cognitive therapists generally deal with childhood experiences in a peripheral manner.

A crucial difference between the two approaches is in the importance of experiential work, such as imagery and dialogues. Although a small minority of cognitive therapists have begun to incorporate experiential work (Smucker & Dancu, 1999), the majority do not see this as central to treatment and use imagery primarily for behavioral rehearsal. In contrast, schema therapists view experiential techniques as one of

four equal components of treatment and devote considerable time in therapy to these strategies. It is difficult to understand the reluctance of most cognitive therapists to incorporate these strategies more widely, as it is generally accepted in the cognitive literature that “hot cognitions” (when the patient is experiencing strong affect) can be changed more readily than “cold cognitions” (when the patient’s affect is flat). Experiential techniques can sometimes be the only way to stimulate hot cognitions in the session.

Another primary difference is in the role of the therapy relationship. Both therapies acknowledge the importance of the relationship for effective therapy, yet they utilize it in very different ways. Cognitive therapists view the therapy relationship primarily as a vehicle to motivate the patient to comply with the treatment (e.g., completing homework assignments). They recommend that the therapist focus on cognitions related to the therapy relationship when the relationship appears to be impeding progress. However, the relationship is not generally considered to be a primary vehicle of change but rather a medium that allows change to take place. To use a medical analogy, cognitive techniques are viewed as the “active ingredients” for change, and the therapy relationship is considered the “base” or “vehicle” through which the change agent is delivered.

In schema therapy, the therapy relationship is one of the four primary components of change. As mentioned earlier in the chapter, schema therapists utilize the relationship in two ways. The first involves observing schemas as they are activated in the session and then using a variety of procedures to assess and modify these schemas within the therapy relationship. The second function involves limited reparenting. This process involves utilizing the therapy relationship as a “corrective emotional experience” (Alexander & French, 1946). Within the appropriate limits of therapy, the therapist acts toward the patient in ways that serve as an antidote to early deficits in the patient’s parenting.

In terms of style, the schema therapist utilizes empathic confrontation more than collaborative empiricism. Cognitive therapists use guided discovery to help patients see how their cognitions are distorted. It has been our experience that characterological patients cannot typically see a realistic, healthy alternative to their schemas without direct instruction from the therapist. Schemas are so deeply ingrained and implicit that questioning and empirical investigation alone are not enough to allow these patients to see their own cognitive distortions. Thus the schema therapist teaches the healthy perspective by empathizing with the schema view while confronting the patient with the reality that the schema view is not working and is not in line with reality as others see it. The schema therapist must constantly confront the patient in this way or the patient slips back into the unhealthy schema perspective. As we tell patients, “the schema fights for

survival.” This concept of doing battle with the schema is not central to cognitive therapy.

Because schemas are far more resistant to change than are other levels of cognition, the course of treatment utilizing schema therapy for Axis II disorders is significantly longer than brief treatment that uses cognitive therapy for Axis I disorders. It is unclear, however, whether cognitive therapy and schema therapy differ in duration for Axis II problems.

Both in conceptualizing a case and in implementing change strategies, schema therapists are more concerned with changing long-term dysfunctional life patterns than with altering discrete dysfunctional behaviors in the current life situation (although both are necessary). Cognitive therapists, because they are focused on rapid symptom reduction, are much less likely to inquire about such long-term problems as dysfunctional partner choices, subtle problems with intimacy, avoidance of important life changes, or core unmet needs, such as nurturance and validation. Along the same lines, cognitive therapists generally do not place central importance on identifying and changing lifelong coping styles, such as schema avoidance, surrender, and overcompensation. Yet, in our experience, it is exactly these coping mechanisms—not simply the rigid core beliefs or schemas—that often make patients with personality disorders so difficult to treat.

We alluded earlier in this section to the concept of modes. Although cognitive and schema therapies both incorporate the concept of a mode, cognitive therapists have not yet elaborated techniques for altering them. Schema therapists have already identified 10 common schema mode states (based on Young's definition noted earlier in the chapter) and have developed a full range of treatment strategies, such as mode dialogues, to treat each individual mode. Mode work forms the basis of schema therapy for patients with borderline and narcissistic personality disorders.

### Psychodynamic Approaches

Schema therapy has many parallels to psychodynamic models of therapy. Two major elements shared by both approaches are the exploration of the childhood origins of current problems and the focus on the therapy relationship. In terms of the therapy relationship, the modern psychodynamic shift toward expressing empathy and establishing a genuine relationship (cf., Kohut, 1984; Shane, Shane, & Gales, 1997) is compatible with our notions of limited reparenting and empathic confrontation. Both psychodynamic and schema approaches value intellectual insight. Both stress the need for the emotional processing of traumatic material. Both alert therapists to transference and countertransference issues. Both affirm the im-

portance of personality structure, asserting that the kind of personality structure the patient presents holds the key to effective therapy.

There are also essential differences between schema therapy and psychodynamic models. One key difference is that psychoanalysts have traditionally attempted to remain relatively neutral, whereas schema therapists endeavor to be active and directive. In contrast to most psychodynamic approaches, schema therapists provide limited reparenting, partially meeting the patient's unmet emotional needs in order to heal schemas.

Another major difference is that, unlike classical analytic theories, the schema model is not a drive theory. Instead of focusing on instinctual sexual and aggressive impulses, schema theory emphasizes core emotional needs. Schema theory rests on the principle of cognitive consistency. People are motivated to maintain a consistent view of themselves and the world and tend to interpret situations as confirming their schemas. In this sense, the schema approach is more a cognitive than a psychodynamic model. Where psychoanalysts see defense mechanisms against instinctual wishes, schema therapists see styles of coping with schemas and unmet needs. The schema model views the emotional needs the patient is trying to fulfill as inherently normal and healthy.

Finally, psychodynamic therapists tend to be less integrative than schema therapists. Psychodynamically oriented therapists rarely assign homework, nor are they likely to utilize imagery or role-playing techniques.

### Bowlby's Attachment Theory

Attachment theory, based on the work of Bowlby and Ainsworth (Ainsworth & Bowlby, 1991), had a significant impact on schema therapy, especially on the development of the Abandonment schema and on our conception of borderline personality disorder. Bowlby formulated attachment theory by drawing on ethology, systems, and psychoanalytic models. The main tenet is that human beings (and other animals) have an attachment instinct that aims at establishing a stable relationship with the mother (or other attachment figure). Bowlby (1969) conducted empirical studies of children separated from their mothers and noted universal responses. Ainsworth (1968) elaborated the idea of the mother as a secure base from which the infant explores the world and demonstrated the importance of maternal sensitivity to infant signals.

We have incorporated the idea of the mother as a secure base into our notion of limited reparenting. For patients with BPD (and with other, more severe disorders), limited reparenting provides a partial antidote to the patient's Abandonment schema: The therapist becomes the secure emotional base the patient never had, within the appropriate limits of a therapy relationship. To some extent, almost all patients with schemas in the Discon-

nection and Rejection domain (with the exception of the Social Isolation schema) require the therapist to become a secure base.

In the schema model, echoing Bowlby, childhood emotional development proceeds from attachment to autonomy and individuation. Bowlby (1969, 1973, 1980) argues that a stable attachment to mother (or other main attachment figure) is a basic emotional need that precedes and promotes independence. According to Bowlby, a well-loved child is likely to protest separation from parents but later develops more self-reliance. Excessive separation anxiety is a consequence of aversive family experiences, such as loss of a parent or repeated threats of abandonment by a parent. Bowlby also pointed out that, in some cases, separation anxiety can be too low, creating a false impression of maturity. An inability to form deep relationships with others may ensue when the replacement of attachment figures is too frequent.

Bowlby (1973) proposed that human beings are motivated to maintain a dynamic balance between preserving familiarity and seeking novelty. In Piagetian (Piaget, 1962) terms, the individual is motivated to maintain a balance between assimilation (integrating new input into existing cognitive structures) and accommodation (changing existing cognitive structures to fit new input). Early Maladaptive Schemas interfere with this balance. Individuals in the grip of their schemas misinterpret new information that would correct the distortions that stem from these schemas. Instead, they *assimilate* new information that could disprove their schemas, distorting and discounting new evidence so that their schemas remain intact. Assimilation, therefore, overlaps with our concept of schema perpetuation. The function of therapy is to help patients *accommodate* new experiences that disprove their schemas, thereby promoting schema healing.

Bowlby's (1973) notion of internal working models overlaps with our notion of Early Maladaptive Schemas. Like schemas, an individual's internal working model is largely based on patterns of interaction between the infant and the mother (or other main attachment figure). If the mother acknowledges the infant's need for protection, while simultaneously respecting the infant's need for independence, the child is likely to develop an internal working model of the self as worthy and competent. If the mother frequently spurns the infant's attempts to elicit protection or independence, then the child will construct an internal working model of the self as unworthy or incompetent.

Utilizing their working models, children predict the behaviors of attachment figures and prepare their own responses. The kinds of working models they construct are thus very significant. In this light, Early Maladaptive Schemas are dysfunctional internal working models, and children's characteristic responses to attachment figures are their coping styles. Like schemas, working models direct attention and information

processing. Defensive distortions of working models occur when the individual blocks information from awareness, impeding modification in response to change. In a process similar to schema perpetuation, internal working models tend to become more rigid over time. Patterns of interacting become habitual and automatic. In time, working models become less available to consciousness and more resistant to change as a result of reciprocal expectancies.

Bowlby (1988) addressed the application of attachment theory to psychotherapy. He noted that a large number of psychotherapy patients display patterns of insecure or disorganized attachment. One primary goal of psychotherapy is the reappraisal of inadequate, obsolete internal working models of relationships with attachment figures. Patients are likely to impose rigid working models of attachment relationships onto interactions with the therapist. The therapist and patient focus first on understanding the origin of the patient's dysfunctional internal working models; then the therapist serves as a secure base from which the patient explores the world and reworks internal working models. Schema therapists incorporate this same principle into their work with many patients.

### Ryle's Cognitive-Analytic Therapy

Anthony Ryle (1991) has developed "cognitive-analytic therapy," a brief, intensive therapy that integrates the active, educational aspects of cognitive-behavioral therapy with psychoanalytic approaches, especially object relations. Ryle proposes a conceptual framework that systematically combines the theories and techniques derived from these approaches. As such, cognitive-analytic therapy overlaps considerably with schema therapy.

Ryle's (1991) formulation is called the "procedural sequence model." He uses "aim-directed activity" rather than schemas as his core conceptual construct. Ryle considers neurosis to be the persistent use of and failure to modify procedures that are ineffective or harmful. Three categories of procedures account for most neurotic repetition: traps, dilemmas, and snags. A number of the patterns Ryle describes overlap with schemas and coping styles.

In terms of treatment strategies, Ryle encourages an active and collaborative therapeutic relationship that includes a comprehensive and depth-oriented conceptualization of the patient's problems, just as schema therapy does. The therapist shares the conceptualization with the patient, including an understanding of how the patient's past led to current problems and a listing of the various maladaptive procedures the patient uses to cope with these problems. In cognitive-analytic therapy, the main treatment strategies are transference work to clarify themes and diary-keeping

about maladaptive procedures. Schema therapy includes both of these components but adds many other treatment strategies.

Cognitive-analytic therapy utilizes a threefold change method: new understanding, new experience, and new acts. However, new understanding is Ryle's main focus, what he considers the most powerful agent of change. In cognitive-analytic therapy, the Change Phase primarily involves helping patients become aware of negative patterns in their lives. Ryle's emphasis is on insight: "In CAT the therapeutic emphasis is put most strongly on strengthening the higher levels (of cognition), in particular through reformulation, which modifies appraisal processes and promotes active self-observation" (Ryle, 1991, p. 200).

In schema therapy, insight is a necessary, but not sufficient, component of change. As we move toward treatment of more severe pathology, such as occurs in patients with borderline and narcissistic disorders, we find that insight becomes less important relative to the new experience provided by experiential and behavioral approaches. Ryle (1991) views new understanding as the main vehicle for change with patients with BPD. His focus is on what he calls "sequential diagrammatic reformulations." These are written diagrams summarizing the case conceptualization. The therapist places the diagrams on the floor in front of the patient and refers to them frequently. Sequential diagrammatic reformulations are intended to help patients with BPD develop an "observing eye."

Schema therapy diverges from cognitive-analytic therapy in several ways. Schema therapy places more emphasis on the elicitation of affect and on limited reparenting, especially with patients who have severe characterological disorders. Schema therapy thus does more to facilitate change on an emotional level. Ryle (1991) acknowledges that procedures for activating affect, such as Gestalt techniques or psychodrama, may be appropriate in some cases to help patients move beyond intellectual insight. In contrast, Young views experiential techniques, such as imagery and dialogues, as useful for nearly all patients.

In Ryle's (1991) approach, the therapist interacts primarily with the adult side of the patient, the Healthy Adult mode, and only indirectly with the child side of the patient, the Vulnerable Child mode. According to the schema approach, patients with BPD are like very young children and need to attach securely to the therapist before separating and individuating.

### Horowitz's Person Schemas Therapy

Horowitz has developed a framework that integrates psychodynamic, cognitive-behavioral, interpersonal, and family systems approaches. His model emphasizes roles and beliefs based on "person schemas theory"

(Horowitz, 1991; Horowitz, Stinson, & Milbrath, 1996) A person schema is a template, usually unconscious, comprising one's views of self and others, and it is formed from memory residues of childhood experiences (Horowitz, 1997). This definition is virtually identical to our notion of an Early Maladaptive Schema. Horowitz focuses on the general structure of all schemas, whereas Young delineates specific schemas underlying most negative life patterns.

Horowitz (1997) elaborates on what he terms "role relationship models." Horowitz associates each role relationship with (1) an underlying wish or need (the "desired role relationship model"); (2) a core fear (the "dreaded role relationship model"); and (3) role relationship models that defend against the dreaded role relationship model. In terms of schema theory, these correspond loosely to core emotional needs, Early Maladaptive Schemas, and coping styles. Horowitz (1997) explains that a role relationship includes scripts for transactions, intentions, emotional expressions, actions, and critical evaluations of actions and intentions. As such, a role relationship contains aspects of both schemas and coping styles. The schema model conceptualizes schemas and coping responses separately, as schemas are not directly linked to specific actions. Different individuals handle the same schema with distinctive coping styles, depending on innate temperament and other factors.

Horowitz (1997) also defines "states of mind," which are similar to our concept of modes. A state of mind is "a pattern of conscious experiences and interpersonal expressions. The elements that combine to form the pattern that is recognized as a state include verbal and nonverbal expression of ideas and emotions" (Horowitz, 1997, p. 31). Horowitz does not present these states of mind as lying along a continuum of dissociation. In the schema model, more severely disturbed patients, such as those with narcissistic and borderline personality disorders, flip into states of mind that fully subsume the patient's sense of self. More than experiencing a state of mind, the patient experiences a different "self" or "mode." This distinction is important in that the degree of dissociation associated with a mode dictates major modifications in technique.

What Horowitz (1997) calls "defensive control processes" also resemble Young's coping styles. Horowitz identifies three major categories:

1. Defensive control processes that involve avoidance of painful topics through the content of what is expressed (e.g., shifting attention away or minimizing importance)
2. Those that involve avoidance through the manner of expression (e.g., verbal intellectualization)
3. Those that involve coping by shifting roles (e.g., abruptly shifting to a passive role or a grandiose role).

Within this typology, Horowitz (1997) covers many of the phenomena encompassed by schema avoidance, surrender, and overcompensation.

During the treatment, the therapist supports the patient, counteracts avoidance by redirecting the patient's attention, interprets dysfunctional attitudes and resistance, and helps the patient plan trials of new behavior. As in Ryle's (1991) work, insight is the most vital part of treatment. The therapist clarifies and interprets, focusing the patient's thoughts and discourse on role-relationship models and defensive control processes. The goal is for new "supraordinate" schemas to gain priority over immature and maladaptive ones.

In comparison with schema therapy, Horowitz (1997) does not provide detailed or systematic treatment strategies and does not utilize experiential techniques or limited reparenting. Schema therapy places more emphasis on activating affect than does Horowitz's approach. The schema therapist accesses what Horowitz (1997) terms "regressive states"—and what we term the patient's Vulnerable Child mode.

### Emotionally Focused Therapy

Emotionally focused therapy, developed by Leslie Greenberg and his colleagues (Greenberg, Rice, & Elliott, 1993; Greenberg & Paivio, 1997) draws on experiential, constructivist, and cognitive models. Like schema therapy, emotionally focused therapy is strongly informed by attachment theory and therapy process research.

Emotionally focused therapy places emphasis on the integration of emotion with cognition, motivation, and behavior. The therapist activates emotion in order to repair it. Much weight is placed on identifying and repairing emotion schemes, which Greenberg (Greenberg & Paivio, 1997) defines as sets of organizing principles, idiosyncratic in content, that tie together emotions, goals, memories, thoughts, and behavioral tendencies. Emotion schemes emerge through an interplay of the individual's early learning history and innate temperament. When activated, they serve as powerful organizing forces in the interpretation of and response to events in one's life. Similar to the schema model, the ultimate aim of emotionally focused therapy is to change these emotion schemes. Therapy brings into the patient's awareness "inaccessible internal experience . . . in order to construct new schemes" (Greenberg & Paivio, 1997, p. 83).

Like schema therapy, emotionally focused therapy relies heavily on the therapeutic working alliance. Emotionally focused therapy utilizes this alliance to develop an emotionally focused "empathic dialogue" that stimulates, focuses, and attends to the patient's emotional concerns. To be able to engage in this dialogue, therapists must first create a sense of safety and trust. Once this sense is securely established, therapists engage in a deli-

cate dialectic balance of “following” and “leading,” accepting and facilitating change. This process is similar to the schema model ideal of empathic confrontation.

Like schema therapy, emotionally focused therapy recognizes that the mere activation of emotion is not sufficient to engender change. In emotionally focused therapy, change requires a gradual process of emotional activation through the use of experiential techniques, overcoming avoidance, interrupting negative behaviors, and facilitating emotional repair. The therapist helps patients recognize and express their primary feelings, verbalize them, and then access internal resources (e.g., adaptive coping responses). In addition, emotionally focused therapy prescribes different interventions for different emotions.

Despite considerable similarities, several theoretical and practical differences distinguish emotionally focused therapy from the schema model. One difference is the primacy emotionally focused therapy gives to affect within emotion schemes compared with the schema model's more egalitarian view of the roles played by affect, cognition, and behavior. Additionally, Greenberg maintains that there are an “infinite amount of unique emotional schemes” (Greenberg & Paivio, 1997, p. 3), whereas the schema model defines a finite set of schemas and coping styles and provides appropriate interventions for each one.

The emotionally focused therapy model organizes schemes in a complex, hierarchical organization, distinguishing between primary, secondary, and instrumental emotions, and breaking these further into adaptive, maladaptive, complex, and socially constructed emotions. The type of emotion scheme suggests specific intervention goals, taking into account whether the emotion is internally or externally focused (e.g., sadness vs. anger) and whether it is currently overcontrolled or undercontrolled. Compared with the more parsimonious schema model, emotionally focused therapy places a considerable burden on the therapist to analyze emotions accurately and to intervene with them in very specific ways.

The assessment process in emotionally focused therapy relies primarily on moment-by-moment experiences in the therapy room. Greenberg and Paivio (1997) contrast these techniques with approaches that rely on initial case formulations or those that rely on behavioral assessments. Although the schema model utilizes in-session information, it is more multifaceted, including structured imagery sessions, schema inventories, and attunement to the therapy relationship.

## SUMMARY

Young (1990) originally developed schema therapy to treat patients who had failed to respond adequately to traditional cognitive-behavioral treat-

ment, especially patients with personality disorders and significant characterological issues underlying their Axis I disorders. These patients violate several assumptions of cognitive-behavioral therapy and thus are difficult to treat successfully with this method. More recent revisions of cognitive therapy for personality disorders by Beck and his colleagues (Beck et al., 1990; Alford & Beck, 1997) are more consistent with schema therapy formulations. However, there are still significant differences between these approaches, especially in terms of conceptual emphasis and the range of treatment strategies.

Schema therapy is a broad, integrative model. As such, it has considerable overlap with many other systems of psychotherapy, including psychodynamic models. However, most of these approaches are narrower than schema therapy, either in terms of the conceptual model or the range of treatment strategies. There are also significant differences in the therapy relationship, the general style and stance of the therapist, and the degree of therapist activity and directiveness.

Early Maladaptive Schemas are broad, pervasive themes or patterns regarding oneself and one's relationships with others that are dysfunctional to a significant degree. Schemas comprise memories, emotions, cognitions, and bodily sensations. They develop during childhood or adolescence and are elaborated throughout one's lifetime. Schemas begin as adaptive and relatively accurate representations of the child's environment, but they become maladaptive and inaccurate as the child grows up. As part of the human drive for consistency, schemas fight for survival. They play a major role in how individuals think, feel, act, and relate to others. Schemas are triggered when individuals encounter environments reminiscent of the childhood environments that produced them. When this happens, the individual is flooded with intense negative affect. LeDoux's (1996) research on the brain systems involved with fear conditioning and trauma suggests a model for the biological underpinnings of schemas.

Early Maladaptive Schemas are the result of unmet core emotional needs. Aversive childhood experiences are their primary origin. Other factors play a role in their development, such as emotional temperament and cultural influences. We have defined 18 Early Maladaptive Schemas in five domains. A great deal of empirical support exists for these schemas and some of the domains.

We define two fundamental schema operations: schema perpetuation and schema healing. Schema healing is the goal of schema therapy. Maladaptive coping styles are the mechanisms patients develop early in life to adapt to schemas, and they result in schema perpetuation. We have identified three maladaptive coping styles: surrender, avoidance, and overcompensation. Coping responses are the specific behaviors through which these three broad coping styles are expressed. There are common coping responses for each schema. Modes are states, or facets of the self, involving

specific schemas or schema operations. We have developed four main categories of modes: Child modes, Dysfunctional Coping modes, Dysfunctional Parent modes, and the Healthy Adult mode.

Schema Therapy has two phases: the Assessment and Education Phase and the Change Phase. In the first phase, the therapist helps patients identify their schemas, understand the origins of their schemas in childhood or adolescence, and relate their schemas to their current problems. In the Change Phase, the therapist blends cognitive, experiential, behavioral, and interpersonal strategies to heal schemas and replace maladaptive coping styles with healthier forms of behavior.