AN INTRODUCTORY GUIDE TO SCHEMA THERAPY:

Adapted for use with the YSQ-R

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AN INTRODUCTORY GUIDE TO SCHEMA-FOCUSED THERAPY: Adapted for use with the YSQ-R

Harry is a very troubled 45-year-old middle-level manager. He has been married for 16 years but he and his wife often resent each other, rarely communicate on an intimate level, and have few moments of real pleasure.

Other aspects of Harry's life have been equally unsatisfying. He doesn't enjoy his work, primarily because he doesn't get along with his co-workers. He is often intimidated by his boss and other people at the office. He has a few friends outside of work, but none that he considers close.

During the past year, Harry's mood became increasingly negative. He was getting more irritable, he had trouble sleeping, and he began to have difficulty concentrating at work. As he became increasingly depressed, he began to eat more and gained 15 pounds. When he thought about taking his own life, he decided it was time to get help. He consulted a psychologist who practices cognitive therapy.

As a result of short-term cognitive therapy techniques, Harry improved rapidly. His mood lifted, his appetite returned to normal, and he no longer thought about suicide. In addition, he was able to concentrate well again and was much less irritable. He also began to feel more in control of his life as he learned how to control his emotions for the first time. But, in some ways, the short-term techniques were not enough. His relationships with his wife and others, while they no longer depressed him as much as they had, still failed to give him much pleasure. He still could not ask for his needs to be met and had few experiences he considered truly enjoyable. The therapist began schema-focused cognitive therapy to help Harry change his long-term life patterns.

This guide will present the schema-focused approach, a recent elaboration of cognitive therapy developed by Dr Jeffrey Young that can help people change long-term patterns, including how they interact with others.

EARLY MALADAPTIVE SCHEMAS (EMS)

A schema is an extremely stable and enduring pattern that develops during childhood and is elaborated throughout an individual's life. We view the world through our schemas. Schemas are important beliefs and feelings about oneself and the environment the individual accepts without question. They are self-perpetuating and are very resistant to change. For instance, children who develop a schema that they are incompetent rarely challenge this belief, even as adults. The schema usually does not go away without therapy. Overwhelming success in people's lives is often insufficient to change the schema. The schema fights for its own survival and, usually, is quite successful.

Even though schemas persist once they are formed, they are not always in our awareness. Usually, they operate in subtle ways, out of our awareness. However, when a schema erupts or is triggered by events, these schemas dominate our thoughts and feelings. People tend to experience extremely negative emotions and have dysfunctional thoughts at these moments. Most people will have at least two or three of these schemas, and often more. A brief description of each of these schemas is provided below.

1. Emotional Deprivation:
The expectation is that others will not adequately meet one's desire for healthy emotional support. 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 with others.
c) *Deprivation of Protection*: absence of strength, direction, or guidance from others.

Examples of core beliefs/assumptions:

- I don't matter
- I can't rely on others to meet my needs
- I'm not special to anyone

Origins of this schema may have involved early experiences where:

- Caregivers were not really tuned into the child's needs and emotions. They had difficulty empathising and connecting with the child's world.
- Caregivers did not give the child enough time and attention for them to develop a sense of being loved and valued.
- Caregivers did not soothe the child adequately. The child, then, may not have learned to soothe themself or to accept soothing from others.
- Caregivers did not adequately guide the child or provide a sense of direction. There was no one solid for the child to rely upon.

2. Abandonment:

This schema refers to the expectation that one will soon lose anyone with whom an emotional attachment is formed. The person believes that one way or another, close relationships will end. There is often a 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. angry outbursts), unreliable, or erratically present; because they will die imminently; or because they will abandon the patient in favour of someone better.

Examples of core beliefs/assumptions:

- I can't trust that others will stick by me
- Eventually, people I love will leave me

Origins of this schema may have involved early experiences where:

- A parent or loved one died or left home when the child was young.
- The child was separated from a primary caregiver for a prolonged period of time (e.g., parents divorced, a parent was hospitalised, the child was sent away to boarding school).
- Caregivers were unstable. They became depressed, angry, drunk, or in some other way withdrawn from the child regularly.
- The child lost the attention of someone important in a significant way (e.g., a new sibling was born, a parent remarried, or a friend chose somebody else).

3. Mistrust:

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

Examples of core beliefs/assumptions:

- I can't trust anyone
- I can't let my guard down
- People will hurt me

Origins of this schema may have involved early experiences where:

- The child was physically and/or sexually abused or assaulted, or sought out by an adult for physical affection that was inappropriate or uncomfortable.
- The child was repeatedly humiliated, teased/bullied, or put down by caregivers or peers.
- People close to the child could not be trusted (e.g., they betrayed confidences, exploited weaknesses. to their advantage, were manipulative, made promises they had no intention of keeping, and lied often).
- Caregivers were mistrusting and warned the child not to trust people outside of the family.

4. Social Isolation:
The feeling that one is isolated from the rest of the world, different from others, and/or not part of any group or community.

Examples of core beliefs/assumptions:
- I don't belong
- I'm different to everyone else

Origins of this schema may have involved early experiences where:
- The child was different to others, because of some qualities (e.g., looks, stuttering, personality feature). They were teased, rejected, humiliated, or ignored by others.
- The child's family was different from other children's families.
- The child was made to feel different from others, even within their own family.

5. Defectiveness:
The feeling that one is defective, bad, unwanted, or inferior, and that one would be unlovable if their 'flaws' were exposed. May involve hypersensitivity to criticism, rejection, and blame; self-consciousness, comparisons, and insecurity around others; or a deep 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).

Examples of core beliefs/assumptions:
- I'm not good enough
- There's something wrong with me
- I'm worthless

Origins of this schema may have involved early experiences where:
- The child was repeatedly criticised, punished, or demeaned.
- The child was made to feel like a disappointment or a burden.
- The child was rejected.
- There was sexual, physical, or emotional abuse.
- The child was repeatedly compared unfavourably with siblings, or their siblings were preferred.

6. 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, ignorant, lower in status, less successful than others, etc.

Examples of core beliefs/assumptions:
- I'm a failure/will inevitably fail
- Nothing I do is as good as other people
- I won't succeed, no matter how hard I try

Origins of this schema may have involved early experiences where:
- There was a caregiver, teacher, or coach who was very critical of the child's performance
- Caregivers and peers of the child were extremely successful, and the child came to believe they could never live up to these high standards or were often compared unfavourably
- The child was not as good as others at school/sports and felt inferior. The child may have had a disability or condition that was not supported or recognised.

7. Dependence:
The belief is that one cannot handle one's everyday responsibilities competently without considerable help from others (e.g., taking care of oneself, solving daily problems, exercising good judgment, tackling new tasks, and making good decisions). Often presents as helplessness.

Examples of core beliefs/assumptions:

- I can't trust my own judgement
- I can't cope on my own

Origins of this schema may have involved early experiences where:

- The child was overprotected and treated as if they were younger than they were. The child may never have had a serious rejection or failure until they left home.
- Caregivers made decisions for the child or interfered with their choices by giving excessive advice, instructions, criticism, or warnings.
- The child was given little or no responsibility.
- The child was criticised for their opinions and competence in everyday tasks.

8. Vulnerability to Harm:

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, being attacked, plane crashes, earthquakes)

Examples of core beliefs/assumptions:

- I'm not safe
- I can't protect myself
- I am vulnerable

Origins of this schema may have involved early experiences where:

- There was a caregiver that was phobic or frightened about specific areas of vulnerability (such as losing control, getting sick, going broke, etc).
- The child was overprotected or continuously warned of specific dangers.
- The home environment did not seem safe physically, emotionally, or financially. Caregivers may
- not have adequately protected the child, or the child grew up in a time/place of significant political, economic, or civil unrest.
- The child or a loved one experienced a serious traumatic event (e.g., a car accident, severe illness, assault).

9. Enmeshment:

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. It may also include feelings of being smothered by or fused with others or insufficient individual identity. Often experienced as a feeling of emptiness and floundering, having no direction, or in extreme cases questioning one's existence.

Examples of core beliefs/assumptions:

- I can't survive without the other person
- I don't know who I am
- I can't separate myself from others

Origins of this schema may have involved early experiences where:

- The family was extremely close and overinvolved with all aspects of each other's lives; boundaries were not respected or established.
- The child was relied upon for emotional support by their parent; their parent was their "best friend".
- The child was rarely apart from caregivers and had little opportunity to develop a sense of self as a separate person.
- Attempts to individuate were met with anger, accusations of betrayal or disloyalty, or other distress.

10. Subjugation:
Excessive surrendering of control to others because one feels coerced – submitting 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 behaviours, uncontrolled outbursts of temper, psychosomatic symptoms, withdrawal of affection, "acting out," substance abuse).

Examples of core beliefs/assumptions:
- I'm not allowed to speak my mind
- I am powerless
- If I expressed what I really felt, I would be punished

Origins of this schema may have involved early experiences where:
- Caregivers or friends punished, threatened, or got angry when the child disagreed.
- Caregivers or friends withdrew emotionally or cut off contact when the child disagreed.
- The child was dominated or "one-upped" whenever they expressed feelings or needs.
- Loved ones tended to become worried, upset, or angry, leaving the child feeling like they had to walk on eggshells.

11. 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 toward those who are taken care of.

Examples of core beliefs/assumptions:
- My own needs aren't important
- I'm responsible for everyone else's feelings/needs
- It is selfish to do things for myself

Origins of this schema may have involved early experiences where:
- Caregivers were absent, physically/emotionally unwell, or overwhelmed by their demands requiring the child to help the family by taking on adult responsibilities.
- There was significant emphasis on selflessness and kindness as a virtue (e.g., religious or moral beliefs).
- The child was made to feel selfish, guilty, or bad if they prioritised their own interests.

12. Emotion Constriction:
The excessive inhibition or disconnection of spontaneous emotion, action, or expression, due to an underlying shame/embarrassment. It involves inhibition of negative impulses (e.g., anger, aggression, sadness), and positive impulses (e.g., joy, affection, sexual excitement, play), difficulty expressing vulnerability or communicating freely about one's thoughts, feelings, and needs, or excessive emphasis on rationality over emotions. There may be a sense of pride in being "a rational person" or holding moral/ethical values in stoicism.

Examples of core beliefs/assumptions:
- Showing emotions means I am weak/vulnerable
- I am strong because my emotions do not sway me
- It is foolish to be emotional

Origins of this schema may have involved early experiences where:

- The child was expected to suppress spontaneous urges in favour of rigid rules, duty, rationality, ethics, or keeping up appearances.
- Expression of emotions was met with ridicule, shaming, judgement, abuse, etc., therefore, it was unsafe to express or experience emotion.
- Expression of emotion or impulsivity was considered a sign of weakness.
- Relationships were enmeshed/co-dependent, so there was no space for the child to express themselves or develop emotionally.

13. Fear of Losing Control:

The excessive inhibition or disconnection of spontaneous emotion, action, or expression, due to a fear that one would otherwise lose control of their impulses resulting in dire consequences. This may include fears of being overwhelmed by emotions (e.g., as in panic/fear or despair), fears of others' response (e.g., abandonment/ rejection, ridicule, judgement), fears of harming self/others (e.g., if giving in to aggressive impulses or intrusive thoughts), fears of 'overindulging' (e.g., losing control of spending, eating). There may be an excessive preoccupation with one's internal state and how one appears to others.

Examples of core beliefs/assumptions:

- If I show how I really feel, it will cause damage
- If I let my emotions go, I won't be able to stop
- I can't cope with my emotions

Origins of this schema may have involved early experiences where:

- The child received judgment and/or punishment if expressing emotions or following an impulse.
- Caregivers frequently flipped between being extremely emotional to extremely restrained; they were emotionally dysregulated.
- Following spontaneous urges was seen to cause harm (e.g., a caregiver was abusive, chaotic, or suffered an addiction).

14. Unrelenting Standards:

The underlying belief is that one must strive to meet very high internalised standards of behaviour and performance, usually to avoid criticism. Typically results in feelings of pressure or difficulty slowing down and in hyper-criticalness 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.
c) *Preoccupation with time and efficiency*, the need to accomplish more.

Examples of core beliefs/assumptions:

- I have to be perfect
- I need to do more
- I can't accept "good enough"

Origins of this schema may have involved early experiences where:

- Caregivers' love was conditional on the child meeting high standards.
- One or both parents were models of high, unbalanced standards.
- Caregivers used shame or criticism when the child failed to meet high expectations.

15. Entitlement:

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) 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 behaviours of others in line with one's desires without empathy or concern for others' needs or feelings.

Examples of core beliefs/assumptions:

- I deserve special treatment
- I should be able to do whatever I want
- I am superior to others

Origins of this schema may have involved early experiences where:

- The child was overindulged or spoiled by caregivers; the child did not learn to hear or tolerate the word "no".
- Caregivers modelled a lack of control over emotions and impulses.
- Caregivers failed to exercise sufficient discipline and boundaries over the child; they did not impose or follow through on consequences.
- The child was made to feel inferior, unloved, or defective and learned to overcompensate by becoming demanding, aggressive, or superior.

16. Insufficient Self-Control:

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 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 fulfilment, commitment, or integrity.

Examples of core beliefs/assumptions:

- I can't control my behaviour
- I can't tolerate discomfort
- I can't stick to my resolutions

Origins of this schema may have involved early experiences where:

- The child was often left to their own devices and lacked a caregiver to provide guidance and discipline toward developing persistence or self-regulation skills.
- The child had a learning or neurodevelopmental disorder/condition that was not adequately treated or supported.

17. Approval 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 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.

Examples of core beliefs/assumptions:

- I only have value if others say so/think so
- I am only worthwhile if I am getting attention/praise
- I must be liked by everyone

Origins of this schema may have involved early experiences where:

- The family was heavily concerned about outward appearances, status, or the opinions of others.
- Caregivers' love and attention were conditional on the child conforming to their preferences.
- The child had difficulty fitting in, so they learned to adapt to behave as they believed others wanted/liked.

18. Negativity:
A pervasive 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 minimising or neglecting the positive or optimistic aspects. Usually includes an exaggerated expectation that things will eventually go seriously wrong even when things seem to be going well. Usually involves fear of making mistakes that might lead to financial collapse, loss, humiliation, or being trapped in a bad situation. As a result, people with this EMS are frequently characterised by chronic worry, vigilance, complaining, or indecision.

Examples of core beliefs/assumptions:

- Bad things always happen to me
- If things are good, it is only temporary

Origins of this schema may have involved early experiences where:

- Significant hardship or adversity (e.g., poverty, early loss/grief, traumatic accidents, abuse) existed.
- Caregivers were highly depressed, pessimistic, or cynical; the child was not sheltered from harsh realities.
- The child was required to take on adult responsibilities at a young age.

19. Punitiveness (Self):
Self-directed hypercriticalness towards one's own mistakes, suffering, or imperfections. Involves a belief that one should be punished or held accountable in some way for failing to meet expectations, a tendency to ignore extenuating circumstances, and an excessive sense of responsibility leading to self-blame, self-directed anger, and difficulty forgiving oneself.

Examples of core beliefs/assumptions:

- I deserve to be punished
- It's all my fault
- I should have known better

Origins of this schema may have involved early experiences where:

- The child was severely punished for making mistakes or committing minor indiscretions.
- There was significant abuse (physical, emotional, psychological) with little/no provocation.
- Mistakes lead to dire/fatal consequences (e.g., war/military contexts, abuse).
- Caregivers were neglectful or abusive unless the child met exceedingly high standards (whether explicit or implicit) for behaviour/achievement.

20. Punitiveness (Others)
Hypercriticalness towards others' mistakes, suffering, or imperfections. Involves a belief that others should be punished or held accountable for their indiscretions, a tendency to ignore extenuating circumstances and naturally human error, and a preoccupation with concepts of justice. There is often anger, impatience, and intolerance toward others and difficulties with empathising and forgiveness. This harsh externalised process may alienate the individual from relationships with others.

Examples of core beliefs/assumptions:

- There's no excuse for mistakes
- It's not fair
- It's all their fault

Origins of this schema may have early experiences where:

- There was an excessive emphasis on adherence to rules, procedures, and regulations (e.g., military families, overly strict parenting style).
- The child was often unfairly blamed (e.g., the child was punished for another's wrongdoing) or witnessed injustices (e.g., bad things happening to "good" people and good things happening to "bad" people).
- Caregivers modelled an externalised coping style (e.g., blamed others, failed to take responsibility for self) and/or cynical worldview.

HOW SCHEMAS WORK

To understand how schemas work, three schema maintenance processes must be defined. These processes are schema support, schema avoidance, and schema compensation. Through these three processes, schemas exert their influence on our behaviour and work to ensure their survival.

1. Schema Support

Schema maintenance refers to the routine processes by which schemas function and perpetuate themselves. This is accomplished by cognitive distortions and self-defeating behaviour patterns.

Earlier, we mentioned that cognitive distortions are a central part of cognitive therapy. These distortions consist of negative interpretations and predictions of life events. Many cognitive distortions are part of the schema maintenance process. The schema will highlight or exaggerate information that confirms it and minimise or deny information that contradicts it.

Schema maintenance works behaviourally as well as cognitively. The schema will generate behaviours that tend to keep the schema intact. For instance, a young man with a Social Isolation schema would have thoughts and behaviour aligned with the schema. At a party, he would have thoughts such as: “No one here likes me” and “I’m not going to succeed at meeting new people”. Behaviourally, he would be more withdrawn and less outgoing.

2. Schema Avoidance

Schema avoidance refers to how people avoid activating schemas. As mentioned earlier, when schemas are activated, this causes extreme negative emotions. People develop ways to avoid triggering schemas to avoid feeling this pain. There are three types of schema avoidance: cognitive, emotional, and behavioural.

Cognitive avoidance refers to people's efforts not to think about upsetting events. These efforts may be either voluntary or automatic. People may voluntarily choose not to focus on an aspect of their personality or an event that they find disturbing. Unconscious processes also help people shut out information that would be too upsetting to confront. People often forget particularly painful events. For instance, children who have been abused sexually often forget their memory completely.

Emotional avoidance is an automatic or voluntary attempt to block painful emotion. When people have painful emotional experiences, they often numb themselves to the feelings to minimise the pain. For instance, a man might talk about how his wife has been acting abusive toward him and say that he feels no anger towards her, only a little annoyance. Some people drink or abuse drugs to numb feelings generated by schemas.

Behavioural avoidance occurs when people often act in such a way as to avoid situations that trigger schemas and thus avoid psychological pain. For instance, a woman with a Failure schema might avoid taking a difficult new job that would benefit her. By avoiding the challenging situation, she avoids any pain, such as intense anxiety, which the schema could generate.

3. Schema Compensation

Schema compensation occurs when an individual behaves in a manner that appears to be the opposite of what the schema suggests avoiding triggering the schema. People with a Dependence schema may structure aspects of their life so that they don’t have to depend on anyone, even when a more balanced approach may be better. For instance, a young man may refuse to go out with women because he fears becoming dependent and will present himself as someone who doesn’t need others to avoid feeling dependent.

EXAMPLES OF MALADAPTIVE COPING RESPONSES

EMS	Examples of Surrender	Examples of Avoidance	Examples of Overcompensation
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
Abandonment	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	Selects abusive partners and permits abuse	Avoids becoming vulnerable and trusting anyone; keeps secrets	Uses and abuses others ("get others before they get you")
Social Isolation	At social gatherings, focuses exclusively on differences from others rather than similarities	Avoids social situations and groups	Becomes a chameleon to fit into groups
Defectiveness	Selects critical and rejecting friends; puts self-down	Avoids expressing true thoughts and feelings and letting others get close	Criticises and rejects others while seeming to be perfect
Failure	Does tasks in a half-hearted or haphazard manner	Avoids work challenges completely; procrastinates on tasks	Becomes an "overachiever" by ceaselessly driving him- or herself
Dependence	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 ("counter dependent")
Vulnerability to Harm	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	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
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
Emotion Constriction	Maintains a calm, emotionally flat demeanour	Avoids situations in which people discuss or express feelings	Tries awkwardly to be the "life of the party" even though it feels forced and unnatural

Fear of Losing Control	Obsessively monitors one's emotions and urges to keep them in check	Avoids situations that might provoke emotional responses	Indulges in emotions and urges indiscriminately
Unrelenting Standards	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
Entitlement	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	Gives up easily on routine tasks	Avoids employment or accepting responsibility	Becomes overly self-controlled or self-disciplined
Approval-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	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; denies unpleasant realities
Punitiveness (Self)	Treats self in a harsh, critical and punitive manner	Avoids others for fear of punishment	Behaves in an overly forgiving way towards self
Punitiveness (Others)	Treats others in a harsh, punitive manner	Avoids interacting with those whose behaviour is disapproved	Behaves in an overly forgiving way towards others

(Yalcin et al., 2021; Young et al., 2003)

CASE EXAMPLES

In this section, six case examples are presented. In each one, the schema processes are demonstrated. Reading this section gives you a better feel for how these processes can operate in real-life situations.

Abby is a young woman whose main schema is Subjugation. She sees people as very controlling even when they are being appropriately assertive. She has thoughts such as "I can't stand up for myself, or they won't like me" and is likely to give in to others (Schema Support). At other times she decides that no one will get the better of her and becomes very controlling (Schema Compensation). Sometimes when people make unreasonable demands on her, she minimises the importance of her feelings and has thoughts like "It's not that important to me what happens". At other times she avoids acquaintances with whom she has trouble standing up for herself (Schema Avoidance).

Stewart's main schema is Failure. Whenever he is faced with a possible challenge, he tends to think he is incapable. He often tries half-heartedly, guaranteeing that he will fail and strengthening the belief that he is incapable (Schema Support). He often makes great efforts to present himself in an unrealistically positive light by spending excessive amounts of money on items such as clothing and automobiles (Schema Compensation). Often, he avoids triggering his schema by staying away from challenges altogether and convinces himself that the challenge is not worth taking (Schema Avoidance).

Rebecca's core schema is Defectiveness. She believes that there is something basically wrong with her and that if anyone gets too close, the person will reject her. She chooses partners who are extremely critical of her and confirm her view that she is defective (Schema Support). Sometimes she has an excessive defensive reaction and counterattacks when confronted with even mild criticism (Schema Compensation). She also ensures that none of her partners gets too close to avoid them seeing her defectiveness and rejecting her (Schema Avoidance).

Michael is a middle-aged man whose main schema is Dependence. He sees himself as incapable of doing daily tasks on his own and generally seeks the support of others. Whenever he can, he chooses to work with people who help him out to an excessive degree. This keeps him from developing the skills needed to work alone and confirms his view of himself as someone who needs others to help him (Schema Support). At times, when he would be best off taking advice from other people, he refuses to do so (Schema Compensation). He reduces his anxiety by procrastinating as much as he can get away with (Schema Avoidance).

Ann's core schema is Social Isolation. She sees herself as being different from other people and not fitting in. When she does things as part of a group, she does not get really involved (Schema Support). At times she gets very hostile towards group members and can be very critical of the group as a whole (Schema Compensation). At other times, she avoids group activities altogether (Schema Avoidance).

Sam's central schema is Emotional Deprivation. He chooses partners who are incapable of giving to other people and then acts in a manner that makes it even more difficult for them to give to him (Schema Support). He will sometimes act very demanding, and belligerently and provoke fights with his partners (Schema Compensation). Sam avoids getting too close to women yet denies having any problems in this area (Schema Avoidance).

THERAPEUTIC PROCESS – CHANGING SCHEMAS

In schema-focused therapy, the goal of the treatment is to weaken the early maladaptive schemas as much as possible and build up the person's healthy side. An alliance is formed between the therapist and the healthy part of the patient against the schemas.

The first step in therapy is to assess the patient comprehensively. The main goal of this assessment is to identify the schemas that are most important in the patient's psychological makeup. There are several steps to this process. The therapist will generally want to know about recent events or circumstances in the patients' lives that have led them to come for help. The therapist will then discuss the patient's life history and look for patterns that may be related to schemas.

There are several other steps the therapist will take in assessing schemas. There is a questionnaire that the patient fills out, listing many of the thoughts related to the different schemas; items on this questionnaire can be rated as to how relevant they are to the patient's life.

There are also various imagery techniques that the therapist can use to assess schemas. One specific technique involves asking patients to close their eyes and create an image of themselves as children with their families. Often the images that appear will lead to the core schemas.

Jonathan is a 28-year-old executive whose core schema is Mistrust. He came to therapy because he was having bouts of intense anxiety at work, during which he would be overly suspicious and resentful of his co-workers. When asked to create an image of himself with his family, he had two different images. In the first image, he saw himself being terrorised by his older brother. In the second, he saw his alcoholic father coming home and beating his mother while he cowered in fear.

There are many techniques that the therapist can use to help patients weaken their schemas. These techniques can be broken down into four categories: emotive, interpersonal, cognitive, and behavioural. Each category will be briefly discussed, along with a few examples.

Emotive Techniques

Emotive techniques encourage patients to experience and express the emotional aspects of their problems. One way this is done is by having patients close their eyes and imagine conversing with the person to whom the emotion is directed. They are then encouraged to express their emotions as completely as possible in the imaginary dialogue. One woman whose core schema was Emotional Deprivation had several sessions where she had an opportunity to express her anger at her parents for not being there enough for her emotionally. She could distance herself further from the schema each time she expressed these feelings. She could see that her parents had their own problems, which kept them from providing her with adequate nurturance and that she was not always destined to be deprived.

There are many variations on the above technique. Patients may take on the other person's role in these dialogues and express what they imagine their feelings to be. Or they may write a letter to the other person, which they have no intention of mailing so that they can express their feelings without inhibition.

Interpersonal Techniques

Interpersonal techniques highlight the patient's interactions with other people so that the role of the EMS can be exposed. One way is by focusing on the relationship with the therapist. Patients with a Subjugation

schema frequently go along with everything the therapist wants, even when they do not consider the assignment or activity relevant. They then feel resentment towards the therapist, which they display indirectly.

This pattern of compliance and indirect expression of resentment can then be explored to the patient's benefit. This may lead to a useful exploration of other instances in which the patient complies with others and later resents it and how the patient might better cope at those times.

Another type of interpersonal technique involves including a patient's spouse in therapy. A man with a Self-Sacrifice schema might choose a wife who tends to ignore his wishes. The therapist may wish to involve the wife in the treatment to help them explore the patterns in their relationship and change how they interact.

Cognitive Techniques

Cognitive techniques are those in which schema-driven cognitive distortions are challenged. As in short-term cognitive therapy, dysfunctional thoughts are identified, and the evidence for and against them is considered. Then new thoughts and beliefs are substituted. These techniques help the patient see alternative ways to view situations.

The first step in dealing with schemas cognitively is to examine the evidence for and against the specific schema being examined. This involves looking at the patient's life and experiences and considering all the evidence which appears to support or refute the schema. The evidence is then examined critically to see if it does, in fact, provide support for the schema. Usually, the evidence produced will be shown to be in error and not really supportive of the schema.

For instance, consider a young man with an Emotional Deprivation schema. When asked for evidence that his emotional needs will never be met, he mentions instances in which past girlfriends have not met his needs. However, when these past relationships are looked at carefully, he finds that, as part of the schema maintenance process, he has chosen women who cannot give emotionally. This understanding gives him a sense of optimism; if he starts selecting his partners differently, his needs can probably be met.

Another cognitive technique is to have a structured dialogue between the patient and therapist. First, the patient takes the side of the schema, and the therapist presents a more constructive view. Then the two switch sides, giving the patient a chance to verbalise the alternative point of view. After several dialogues, the patient and therapist can construct a prompt card for the patient, which contains a concise statement of the evidence against the schema.

A typical prompt card for a patient with a Defectiveness/Shame schema read: "I know that I feel that there is something wrong with me, but the healthy side knows that I'm OK. Several people have known me very well and have stayed with me for a long time. I know that I can pursue friendships with many people I am interested in".

The patient is always instructed to keep the prompt card available and read it whenever the problem occurs. The patient's belief in the schema will gradually weaken by persistent practice at this and other cognitive techniques.

Behavioural Techniques

Behavioural techniques are those in which the therapist assists the patient in changing long-term behaviour patterns so that schema maintenance behaviours are reduced, and healthy coping responses are strengthened.
One behavioural strategy is to help patients choose appropriate partners capable of engaging in healthy relationships. Patients with the Emotional Deprivation schema tend to choose partners who are not emotionally

giving. A therapist working with such patients would help them through the process of evaluating and selecting new patterns.

Another behavioural technique consists of teaching patients better communication skills. For instance, a woman with a Subjugation schema believes she deserves a raise at work but does not know how to ask for it. One technique her therapist uses to teach her how to speak to her supervisor is role-playing. First, the therapist takes the role of the patient, and the patient takes the role of the supervisor. This allows the therapist to demonstrate how to make the request appropriately. Then the patient gets an opportunity to practice the new behaviours and get the therapist's feedback before changing the behaviour in real-life situations.

In summary, schema-focused therapy can help people understand and change long-term life patterns. The therapy involves identifying early maladaptive schemas and systematically confronting and challenging them.

REFERENCES, FURTHER READING, AND ADDITIONAL RESOURCES

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Additional Resources:

Please visit: https://www.anima.com.au/schema to download the YSQ-R Questionnaire, The YSQ-R Scorer, and access webinars and other materials.