SCHEMA THERAPY

A PRACTITIONER'S GUIDE

JEFFREY E. YOUNG
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To Debbie, Sarah, and Jacob
—J. E. Y.

To my mentor, Dr. David H. Barlow.
All these words can't express my gratitude.
—J. S. K.

To my parents
—M. E. W.

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ABOUT THE AUTHORS

Jeffrey E. Young, PhD, is on the faculty in the Department of Psychiatry at Columbia University. He is also the Founder and Director of the Cognitive Therapy Centers of New York and Connecticut, as well as the Schema Therapy Institute (*institute@schematherapy.com*). Dr. Young has lectured internationally on cognitive and schema therapies for the past 20 years. He has trained thousands of mental health professionals and is widely acclaimed for his outstanding teaching skills.

He is the founder of schema therapy, an integrative approach for longer-term disorders and for treatment-resistant patients, and has published widely in the fields of both cognitive and schema therapies, including two major books—*Cognitive Therapy for Personality Disorders: A Schema-Focused Approach,* written for mental health professionals, and *Reinventing Your Life* (with Janet S. Klosko), a popular self-help book written for the general public. Dr. Young has also served as a consultant on several cognitive and schema therapy research grants, including the National Institute of Mental Health Collaborative Study of Depression, and on the editorial boards of the following journals: *Cognitive Therapy and Research* and *Cognitive and Behavioral Practice*.

Janet S. Klosko, PhD, is Codirector of the Cognitive Therapy Center of Long Island in Great Neck, New York (516-466-8485), and is a senior psychologist at the Schema Therapy Institute in Manhattan and Woodstock Women's Health in Woodstock, New York (845-679-6699). She received her PhD in clinical psychology from the State University of New York (SUNY) at Albany and interned at Brown University Medical School.

While at SUNY, she worked with David H. Barlow, researching and treating anxiety disorders. Dr. Klosko has won the Albany Award for Excellence in Research and the Dissertation Award from the American Psychological Association Section on Clinical Psychology as a Science. She has numerous academic publications and is coauthor (with William Sanderson) of *Cognitive-Behavioral Treatment of Depression,* and (with Jeffrey E. Young) of the popular book *Reinventing Your Life*. She also has a master's degree in English literature.

Marjorie E. Weishaar, PhD, is Clinical Professor of Psychiatry and Human Behavior at Brown University Medical School (*Marjorie_Weishaar@brown.edu*), where she teaches cognitive therapy to psychiatry residents and to psychology interns and postdoctoral fellows. She has also received two teaching awards from Brown Medical School. Dr. Weishaar graduated from the University of Pennsylvania and earned three graduate degrees from The Pennsylvania State University. She was trained in cognitive therapy by Aaron T. Beck, and in schema therapy by Jeffrey E. Young. She is the author of *Aaron T. Beck*, a book on cognitive therapy and its founder, which was recently translated into Chinese. Dr. Weishaar lectures widely and has written numerous articles and book chapters on cognitive therapy, particularly in the area of suicide risk. She is currently in private practice in Providence, Rhode Island.

For general information about schema therapy:
Schema Therapy Institute
36 West 44th Street, Suite 1007
New York, NY 10036
Phone: 212-221-1818, ext. 5
E-mail: *institute@schematherapy.com*
Website: *www.schematherapy.com*

PREFACE

It is difficult to believe that it has been 9 years since we wrote our last major book on schema therapy. During this decade of burgeoning interest in this therapy approach, we continually have been asked, "When are you going to write an up-to-date, comprehensive treatment manual?" With some embarrassment, we had to admit that we had not found the time to take on such a major project.

After 3 years of intensive work, however, we have finally written what we hope will become "the bible" for the practice of schema therapy. We have attempted to include in this volume all the additions and refinements from the past decade, including our revised conceptual model, detailed treatment protocols, case vignettes, and patient transcripts. In particular, we have written extended chapters that describe a major expansion of schema therapy for borderline and narcissistic personality disorders.

During the past 10 years, many changes in the mental health field have had an impact on schema therapy. As practitioners from many orientations have become dissatisfied with the limitations of orthodox therapies, there has been a corresponding interest in psychotherapy integration. As one of the first comprehensive, integrative approaches, schema therapy has attracted many new clinicians and researchers who have been searching for both "permission" and guidance to go beyond the confines of existing models.

One clear sign of this heightened interest in schema therapy has been the widespread use of the Young Schema Questionnaire (YSQ) by clinicians and researchers around the world. The YSQ has already been translated into Spanish, Greek, Dutch, French, Japanese, Norwegian, German,

and Finnish, to indicate just a few of the countries that have adopted elements of this model. The extensive research on the YSQ offers substantial support for the schema model.

Another indication of the appeal of schema therapy has been the success of our two earlier books on schema therapy, even 10 years after their publication: *Cognitive Therapy for Personality Disorders: A Schema-Focused Approach* is now in its third edition, and *Reinventing Your Life,* which has sold more than 125,000 copies, is still available at most major bookstores and has been translated into several languages.

The past decade has also seen the extension of schema therapy beyond personality disorders. The approach has been applied to a wide variety of clinical problems, populations, and disorders, including, among others, chronic depression, childhood trauma, criminal offenders, eating disorders, couple work, and relapse prevention for substance abuse. Often schema therapy is being used to treat predisposing characterological issues in patients with Axis I disorders, once the acute symptoms have abated.

Another important development has been the combining of schema therapy with spirituality. Three books (*Emotional Alchemy* by Tara Bennett-Goleman; *Praying Through Our Lifetraps: A Psycho-Spiritual Path to Freedom* by John Cecero; and *The Myth of More* by Joseph Novello) that blend the schema approach with mindfulness meditation or with traditional religious practices have already been published.

One disappointing development, that we hope will change in the decade to come, is the impact of managed care and cost containment on the treatment of personality disorders in the United States. It has become increasingly difficult for practitioners to get insurance reimbursement and for researchers to obtain federal grants for personality disorders because Axis II treatment generally takes longer and thus does not fit a short-term, managed care model. As a result, the United States has fallen behind many other countries in supporting work on personality disorders.

The result of this reduced support has been a paucity of well-designed outcome studies with personality disorders. (The notable exception is Marsha Linehan's dialectical behavior therapy approach to borderline personality disorder.) This has made it extremely difficult for us to obtain funding for studies that might demonstrate empirical support for schema therapy.

Thus we are turning now to other countries to fund this important research area. We are particularly excited about a major outcome study, directed by Arnoud Arntz, nearing completion in the Netherlands. This large-scale, multisite study compares schema therapy with Otto Kernberg's approach in treating borderline personality disorder. We are eagerly awaiting the results.

For readers who are unfamiliar with schema therapy, we will review what we consider the major advantages of schema therapy over other com-

monly practiced therapies. Compared to most other therapy approaches, schema therapy is more integrative, combining aspects of cognitive, behavioral, psychodynamic (especially object relations), attachment, and Gestalt models. Schema therapy regards cognitive and behavioral components as vital to treatment, yet gives equal weight to emotional change, experiential techniques, and the therapy relationship.

Another key benefit of the schema model is its parsimony and seeming simplicity, on the one hand, combined with depth and complexity, on the other. It is easy for both therapists and patients to understand. The schema model incorporates complex ideas, many of which seem convoluted and confusing to patients receiving other forms of therapy, and presents them in simple and straightforward ways. Thus schema therapy has the commonsense appeal of cognitive-behavioral therapy (CBT), combined with the depth of psychodynamic and related approaches.

Schema therapy retains two vital characteristics of CBT: It is both structured and systematic. The therapist follows a sequence of assessment and treatment procedures. The assessment phase includes the administration of a number of inventories that measure schemas and coping styles. Treatment is active and directive, going beyond insight to cognitive, emotive, interpersonal, and behavioral change. Schema therapy is also valuable in the treatment of couples, helping both partners to understand and heal their schemas.

Another advantage of the schema model is its specificity. The model delineates specific schemas, coping styles, and modes. In addition, schema therapy is notable for the specificity of the treatment strategies, including guidelines about providing the appropriate form of limited reparenting for each patient. Schema therapy provides a similarly accessible method for understanding and working with the therapy relationship. Therapists monitor their own schemas, coping styles, and modes as they work with patients.

Finally, and perhaps most important, we believe that the schema approach is unusually compassionate and humane, in comparison with "treatment as usual." Schema therapy normalizes rather than pathologizes psychological disorders. Everyone has schemas, coping styles, and modes—they are just more extreme and rigid in the patients we treat. The approach is also sympathetic and respectful, especially toward the most severe patients, such as those with borderline personality disorder, who are often treated with minimal compassion and much blame in other therapies. The concepts of "empathic confrontation" and "limited reparenting" ground therapists in a caring attitude toward patients. The use of modes eases the process of confrontation, allowing the therapist to aggressively confront rigid, maladaptive behaviors, while still retaining an alliance with the patient.

In closing, we highlight some of the new developments in schema

therapy during the past decade: First, there is a revised and much more comprehensive list of schemas, containing 18 schemas in five domains. Second, we have developed new, detailed protocols for the treatment of borderline and narcissistic patients. These protocols have expanded the scope of schema therapy, primarily with the addition of the schema mode concept. Third, there is a much greater emphasis on coping styles, especially avoidance and overcompensation, and on altering coping styles through pattern-breaking. Our goal is to replace maladaptive coping styles with healthier ones that enable patients to meet their core emotional needs.

As schema therapy has developed and matured, we have placed much more emphasis on limited reparenting with all patients, but especially those with more severe disorders. Within the appropriate bounds of the therapeutic relationship, the therapist attempts to fulfill the patient's unmet childhood needs. Finally, there is more focus on the therapist's own schemas and coping styles, especially in regard to the therapy relationship.

We hope that this volume will provide therapists with a new way of approaching patients with chronic, longer-term themes and patterns, and that schema therapy will provide significant benefits for those extremely difficult and needy patients whom our approach is designed to treat.

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Jeffrey E. Young

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Marjorie E. Weishaar

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CONTENTS

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[1] helps to explain the reason Young felt that the development of schema therapy was so impor-

[1]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.

(*continued on page 2*)

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 disor-

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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.[2]

[2]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.)*

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.

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 tempter 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	*Conditional schemas*
Abandonment/Instability	Subjugation
Mistrust/Abuse	Self-Sacrifice
Emotional Deprivation	Approval-Seeking/Recognition-Seeking
Defectiveness	Emotional Inhibition
Social Isolation	Unrelenting Standards/Hypercriticalness
Dependence/Incompetence	
Vulnerability to Harm or Illness	
Enmeshment/Undeveloped Self	
Failure	
Negativity/Pessimism	
Punitiveness	
Entitlement/Grandiosity	
Insufficient Self-Control/Self-Discipline	

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.[3]
- *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.

[3]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.