Schema Therapy

The CBT Distinctive Features Series
Series editor: Windy Dryden

Eshkol Rafaeli, David P. Bernstein and Jeffrey Young

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Schema Therapy combines proven cognitive behavioral therapy techniques with elements of interpersonal, experiential, and psychodynamic therapies in order to help people with long-term mental health problems including personality disorders and chronic depression. Schema Therapy suggests that many negative cognitive conditions are based on past experiences, and therefore provides models for challenging and modifying negative thoughts and behaviors in order to provoke change.

In this book, Eshkol Rafaeli, David Bernstein and Jeffrey Young – pioneers of the Schema Therapy approach – indicate the 30 distinctive features of Schema Therapy, and how the method fits into the broader CBT spectrum.

Divided into two parts, Theoretical Points and Practical Points. This book provides a concise introduction for those new to the technique, as well as a discussion of how it differs from the other cognitive behavioral therapies for those experienced in the field.

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Cognitive behavior therapy (CBT) occupies a central position in the move towards evidence-based practice and is frequently used in the clinical environment. Yet there is no one universal approach to CBT and clinicians speak of first-, second-, and even third-wave approaches.

This series provides straightforward, accessible guides to a number of CBT methods, clarifying the distinctive features of each approach. The series editor, Windy Dryden, successfully brings together experts from each discipline to summarize the 30 main aspects of their approach divided into theoretical and practical features.

The CBT Distinctive Features Series will be essential reading for psychotherapists, counselors, and psychologists of all orientations who want to learn more about the range of new and developing cognitive behavioral approaches.

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Distinctive Features

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Introduction

Cognitive behavioral therapy (CBT) has developed a strong identity as an umbrella term for time-limited evidence-based treatments for Axis I disorders. Yet CBT models for addressing personality disorders and other enduring patterns of relational and emotional difficulties are gaining greater attention. One of the leading models is Schema Therapy, first introduced by Young (1990) and more recently elaborated by Young and his colleagues (Young, Klosko, & Weishaar, 2003).

Schema Therapy is an integrative approach, bringing together elements from cognitive therapy (and CBT more generally), attachment and object relations theories, and Gestalt and experiential therapies. Our aim is to present the features that distinguish Schema Therapy within the broader cognitive behavioral field. As we make clear in the ensuing chapters, there are both theoretical and practical distinctions. But some overarching distinctions are worth noting here. First, unlike more traditional CBT approaches, Schema Therapy is explicitly concerned with the development (etiology) of current symptoms, and not only with the factors that maintain them. Second, it places a great emphasis on the therapist–patient

relationship, and on providing within it both a corrective emotional experience and empathic confrontation. Third, it sets a clear goal to which the therapist should aspire: helping patients understand their core emotional needs and learn ways of getting those needs met in an adaptive manner, which requires altering long-standing cognitive, emotional, relational, and behavioral patterns.

The first half of this book (Points 1–15) details the theoretical model espoused by schema therapists. This model devotes great attention to core universal emotional needs (Point 1), and argues that maladaptive schemas (Points 2 and 3) emerge when these needs are not met. It also recognizes the existence of three broad and maladaptive coping styles: surrender, avoidance, and overcompensation (presented in Point 4 and detailed in Points 5–7).

In the past 15 years, a refinement of Schema Therapy has led to the development of an additional construct, that of *modes*, which has become crucial to the work of schema therapists. We describe this concept generally (Point 8) and then pay greater attention to the main types of modes encountered in clinical work (Points 9–13). Finally, we conclude the theoretical half of the book with a discussion of the therapeutic stances central to Schema Therapy: limited reparenting and empathic confrontation (Points 14–15).

The second half of this book (Points 16–30) discusses the application of Schema Therapy. It begins, as the therapy itself does, with the assessment phase (Points 16–18) and with the culminating case conceptualization which is presented to the patient and which guides the subsequent treatment (Point 19). It then reviews the four large toolboxes that schema therapists have at their disposal, and that include relational, cognitive, emotion-focused, and behavioral techniques (Points 20–23), as well as specific ideas for working with modes (Point 24). The following points (25–27) explore the use of Schema Therapy with particular patient populations (individuals with borderline, narcissistic, and antisocial personality, as well as couples

experiencing relational distress). Point 28 is devoted to the interplay between Schema Therapy (for long-standing issues) and other CBT and evidence-based treatments (for more acute Axis I disorders or symptoms). Point 29 returns to the issue of limited reparenting, this time from a practical perspective. And Point 30 highlights the importance of attending to the therapists' own schemas and coping styles, as they come in contact with their patients' needs, schemas, coping styles, and modes.

This last point highlights one more feature that distinguishes Schema Therapy, particularly when compared with other approaches for the treatment of personality disorders or long-standing relational problems: it is decidedly a compassionate and humane approach. The assumption is that everyone has needs, schemas, coping styles, and modes – they are simply more pronounced and less flexible in the patients we treat.

Part 1

THEORETICAL POINTS

1

Universal core emotional needs

Schema Therapy begins with recognizing a set of universal emotional needs. These include the needs for safety, stability, nurturance, and acceptance, for autonomy, competence, and a sense of identity, for the freedom to express one's needs and emotions, for spontaneity and play, and for a world with realistic limits which fosters the emergence of self-control.

Everyone has emotional needs – in fact, we argue that everyone has these particular needs. Individuals may differ in the strength of particular needs – some people may have a stronger temperamental need for spontaneity and creative expression, some may be particularly wired to crave nurturance. But above and beyond these individual differences lies a universal similarity – we all, fundamentally, have some amount of all of these needs.

Emotional needs are present from childhood; indeed, most are at their strongest in childhood. For example, the need for safety or stability, though life-long, has its strongest implications the more vulnerable or helpless one is.

Psychological health is the ability to get one's needs met in an adaptive manner. The central project of children's development is to get their core needs met; the central project of effective parenting or childrearing is to help the child get these needs met; and the central project of Schema Therapy – its primary objective – is to help adults get their own needs met, even though these needs may not have been met in the past.

In addition to the core universal emotional needs, Schema Therapy recognizes the existence of needs that emerge in adulthood (for example, the need to work and the need to care for others). These needs are also important for psychological

health, but they tend not to be the focus of therapy. One possibility is that when more fundamental (and earlier) emotional needs are met in an adequate manner, individuals have the capacity to handle later needs quite well.

Schema Therapy has its roots in cognitive behavioral therapy (CBT) (as we detailed in the Introduction and will return to in Point 28). But CBT does not typically address universal needs. If needs get invoked in cognitive therapy, it's in an ad-hoc manner, when a patient or a therapist identifies them. Some cognitive behavioral approaches actually disdain needs – grouping them together with "shoulds" and "oughts" – rigid constructs that are best avoided. This is one example of how Schema Therapy departs from other CBT approaches, and of how it integrates useful ideas from other orientations (in this case, emotion-focused, attachment, and dynamic approaches).

Indeed, needs have been the focus of earlier clinical theories (e.g., control/choice theory: Glasser, 1969; the hierarchy of needs: Maslow, 1962) and are gaining some prominence in more recent research in personality, social, and developmental psychology (e.g., Baumeister and Leary's (1995) need for belonging, or the broader work of self-determination theory on the universal needs for autonomy, competence, and relatedness (Deci & Ryan, 2000)).

Needs – especially those for nurturance, warmth, and security – are also central to attachment theory. Attachment theory has been a prominent approach to human development for the past half century, beginning with John Bowlby's strikingly powerful observation that phenomena observed by evolutionary ethologists (like Lorenz and Harlow) have direct implications to child development, and to human social and emotional development more generally. As decades of both human and primate research show, secure attachment early in life serves as the basis for many adaptive processes later on: with a "secure base," the child is able to develop curiosity and exploration, self-soothing and self-regulation, and ultimately the ability to form close emotional bonds.

Attachment theory and research have been major sources of influence on Schema Therapy. The ideas of Bowlby and Ainsworth (as well as of other writers from the British Object Relations School, particularly Margaret Mahler and Donald Winnicott) are one of the three legs on which Schema Therapy stands, and the one which most clearly spells out the notion of needs. (The other two legs, to which we turn in later points, are CBT and experiential/emotion-focused approaches.)

Some of the theories that speak strongly about needs (including, for example, Maslow's hierarchy model as well as attachment theory) give certain needs "privileged" status – viewing them as more basic or fundamental. For example, attachment theory assumes that if attachment security needs are not attained, other (later) needs will be impeded. Schema Therapy avoids making assumptions such as these regarding a "hierarchy" or a gradient of importance. Instead, core needs are all seen as essential and universal, especially in the lives of adults.

A final point about needs as a feature of Schema Therapy: educating patients about needs in general, and about their own unmet (as well as met) needs, can be quite a powerful intervention in its own right. Being told (as many of our patients are) that they are needy, not greedy, and that the therapy is aimed at helping them get their needs met, helps provide a non-judgmental view of the past and a focused, optimistic view of the future.

2

Early maladaptive schema development as a consequence of unmet needs

The concept that gives Schema Therapy its name is of course the *schema*, a word of Greek origin ($\sigma\chi\eta\mu\alpha$) that refers to a pattern or an organizing framework which helps create order in a complex set of stimuli or experiences. Schemata (or as they're more commonly referred to, schemas) have a rich history in a variety of fields, including philosophy, computer science, set theory, and education, to name a few. In psychology, schemas were first introduced in the cognitive/developmental literature, and from there, made their way into cognitive therapy (Beck, 1972).

In cognitive developmental research, the concept of schemas refers to patterns 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. 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. The term "schema" in psychology is probably most commonly associated with Piaget (e.g., 1955), who wrote in detail about schemata in different stages of childhood cognitive development, and with Bartlett (1932), who originated the use of this term and demonstrated the roles of schemata in learning new information, as well as in recalling memories.

Moving from cognitive psychology to cognitive therapy, Beck referred in his early writing (e.g., 1972) to schemata. Yet

the idea that schemas, or broad organizing principles, exist in every person's life and guide the person in making sense of their own life is inherent in many approaches to therapy, cognitive or otherwise. Likewise, many theorists would agree that schemas are often formed early in life, but continue to be elaborated and developed over the lifespan. Also common to many approaches is the notion that schemas, which might have accurately captured earlier life experience, are often brought to bear in current life situations for which they are no longer applicable. In fact, that is exactly what cognitive and developmental psychologists would have predicted – that schemas would operate in a way that maintains our sense of cognitive consistency. That is how schemas function – they serve as shortcuts, bringing us quickly towards what we think is *likely* to be true and saving us the need to carefully process every detail we encounter. In some cases, schemas or shortcuts are quite efficient in helping us reach a fairly accurate grasp of the situation. But in others, they paint quick-and-dirty pictures for us that are inaccurate and distorted. In either case, they help us maintain a stable view of ourselves and our world – whether that stable view is accurate or inaccurate, adaptive or maladaptive.

Stability and predictability sound like good qualities to have, and they very well could be in some instances. For example, one kind of schema – mental scripts – helps us anticipate how one step (e.g., the main course) is going to follow another (e.g., the appetizer) so that we can handle being in an entirely new place (e.g., an unknown restaurant, even one in a foreign country where we do not speak the language) while still keeping our bearings. Even when a schema is not entirely accurate, it may, in some instances, still be harmless. For example, another kind of schema – group stereotypes – can lead us to respect a new acquaintance or to assume her to have some outstanding capacity, solely on the basis of her race, gender, country of origin, etc.

Yet some schemas – especially ones acquired as a result of toxic childhood experiences and related to the self and the