Integrating Schema Therapy with Adlerian Psychology

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Abstract

This literature review examines the integration of Schema Therapy with Adlerian Psychology. It addresses the strengths and weaknesses of each psychodynamic therapy, and how collaboration between the two may offer an elite therapy for deeply engrained personality disorders.
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After nearly a decade of being uncomfortable working under Sigmund Freud’s biological and deterministic point of view, Alfred Alder resigned as president of the Vienna Psychoanalytic Society in 1911 and developed Individual Psychology in 1912 (Adler, 1998; Corey, 2009; Hoffman, 1994). Adler believed Freud was too narrowly focused on biological and instinctual determination, and thus he moved toward social-psychosocial and teleological view of human nature. Adler stressed choice and responsibility, meaning in life, striving for success, and that humans are motivated by primarily social relatedness, purposeful, and goal oriented behavior. Individual Psychology assumes that people are responsible for their own thoughts, feelings, and actions, and are the creators of their own lives (Adler, 1938). Therefore, Adlerians’ basic premise is that if clients can change their thinking then they can change their feelings and behavior (Corey, 2009).

Even though Adler published more than 300 books and articles, (Adler, 1998; Dinkmeyer & Sperry, 2000; Hoffman, 1994) a criticism of Adlerian Theory is its underdevelopment. Adler put more energy in practicing and teaching before organizing and presenting a well-defined and systematic theory (Carlson, Richard, & Maniaci, 1997; Corey, 2009). Because Adler prioritized teaching and practicing before organizing his theory, Corey (2009) explained “many people thought his ideas were somewhat loose and too simplistic” (p.125). Adler himself foresaw individual’s misperception of Individual Psychology, and cautioned those by stating:

Individual Psychology, which is essentially a child of this age, will have a permanent influence on the thought, poetry, and dreams of humanity. It will attract many enlightened disciples, and many more who will hardly know the names of its pioneers. It will be understood by some, but the numbers of those who misunderstand it will be
greater. It will have many adherents, and still more enemies. Because of its simplicity many will think it is too easy, whereas those who know it will recognize how difficult it is (Dreikurs, 1950, p.vii).

Nonetheless, Adler’s basic foundational principles have found their way into many of psychological schools of thought, such as family systems approaches, Gestalt therapy, learning theory, reality therapy, rational emotive behavior therapy, cognitive therapy, person-centered therapy, existential therapy, and the postmodern approaches to therapy (Corey, 2009; Mosak & Maniaci, 1999), even though his name has often been forgotten (Mosak & Maniaci, 1999). Abraham Maslow, Viktor Frankl, Rollo May, Aaron Beck, and Albert Ellis have all acknowledged their debt to Adler (Corey, 2009). Additionally, a study of contemporary counseling theories revealed that many of Adler’s ideas have reappeared in modern approaches with different nomenclature, and without giving Adler proper credit (Watts & Shulman, 2003). O’Connell (1976) coined the phrase, “friends of Adler phenomenon,” to describe the many theorists who have borrowed from Adler without giving him due credit.

Already with a fertile framework, the Adlerian approach can easily implement a variety of cognitive, behavioral, and experimental techniques. Schema Therapy and Adlerian Psychology complement each other well, and it is difficult to ignore the extreme similarities. Moreover, it is not implausible to believe Jeffery Young himself was influenced by Adler’s work, as Young was a student of Aaron Beck’s (Collard, 2004), and Beck has acknowledged Adler’s influence on Cognitive Therapy (Corey, 2009).

Since many other psychological schools have adopted core Adlerian principles, a major strength of Adlerian Psychology is its ability to adapt other theories, methods, and techniques. This integrated Adlerian heartbeat in many other theories allows Adlerian therapists to be
naturally integrative and flexible, thus having an array of methods and a great deal of freedom to work with diverse populations. While Adlerian psychology has been accused of being too loose and underdeveloped, Adlerian therapists have the freedom to be both theoretically integrative and technically eclectic.

The integration of Schema Therapy compliments this Adlerian criticism well, because of Schema Therapy’s structured nature. Adlerian Psychology does not support diagnostic labeling and avoids most other behavioral labeling. Schema Therapy focuses on pervasive and rigid lifestyles, called Schemas (more commonly known as personality disorders) by maintaining eighteen different Schemas in five structured domains. Schema Therapy has the ability to organize presenting behaviors, while also maintaining the dignity of labeling the client that Adlerian therapists are sensitive to. Both therapies coexist well fundamentally, as they both have a psychodynamic presentation and utilize similar insight oriented techniques, such as imagery.

A shared focal point of both therapies is how early life experiences, more importantly the interpretation of these experiences, shape how individuals interact with the world around them (Adler, 1938; Ansbacher & Ansbacher, 1956; Carlson, Watts, & Maniaci, 2006; Dreikurs & Soltz, 1964; Young, Klosko, & Weishaar, 2003). The combination of this alignment on early life experiences and Schema Therapy’s structure creates a harmonious integration of Schema Therapy with Adlerian Psychology.

**The Development of Schema Therapy**

Jeffrey Young, founder of Schema Therapy, began private practice around 1982 and found that Cognitive Therapy (CT) was very successful for 70-80% of his patients. He found that CT proved very successful for most of these patients with major depression. Accordingly, Dr. Beck, founder of CT, had carefully screened his research subjects who suffered from major
depression, most of whom did not have long-term, lifelong problems (Collard, 2004). Young saw a common theme of patients who were not successful with traditional cognitive therapy. These patients suffered with lifelong pervasive characterological patterns. This is when Young developed Schema Therapy, to treat patients with chronic characterological problems, also now known as personality disorders, who were not adequately being treated by traditional cognitive-behavioral therapies (Young, Klosko, & Weishaar, 2003).

As with Adlerian therapy, Schema therapy can also be brief, intermediate, or long term, depending on the individual patient needs. Schema Therapy expands on other cognitive-behavioral therapy by integrating techniques drawn from several other therapies, such as: object relations, attachment theory, Gestalt therapy, and cognitive-behavioral therapy (Young, Klosko, & Weishaar, 2003). Young, Klosko, & Weishaar (2003) state that “Schema Therapy expands from these therapies by placing a 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” (p.5).

Schema therapy addresses the core psychological themes that are typical of patients with personality disorders. The therapy traces problematic schemas from early childhood to the present, with a particular interest in the patient’s interpersonal relationships. It assists therapists and patients make sense of chronic and pervasive problems in a comprehensible manner. The therapist allies with patients, helping them fight, understand the schema origin, and ultimately overcome their schemas (Young, Klosko, & Weishaar, 2003; Collard, 2004).

Both Adlerian Psychology and Schema Therapy adhere to the belief that early life experiences shape the way an individual interprets the world (Mosak & Pietro, 2006; Young, Klosko, & Weishaar, 2003). Both orientations are psychodynamic, and therefore consider
understanding the source of the presenting problems a vital element of enhancing therapeutic movement. Adlerian Psychology avoids most behavioral labeling, while Schema Therapy maintains eighteen different problematic lifestyles, Schemas, in five structured domains. Although individuals may experience the same Schema differently, individuals with similar childhood experiences may likely develop similar Schemas, or develop a Schema within the same Schema Domain (Young, Klosko, & Weishaar, 2003). While there are no absolutes, understanding general Schema origins can assist therapists in assessing and connecting the client’s presenting problems with the appropriate Schema.

**Origin of Schemas**

The term “schema” has an extensive history in the field of psychology, particularly in cognitive development. Within cognitive development, a schema is a pattern of reality or experience to help make sense or explain it to one’s self. Piaget is heavily associated with schemas, and wrote in detail about *schemata* in different stages of childhood cognitive development (Piaget, 1962). Piaget (1936) also used the terms *scheme or schema* to describe infant’s action-structures, and defined scheme as “any action pattern for dealing with the environment (p.34). Adler (1929) first used the term *schema of apperception* to refer to the individual’s self and the world: “The child will not perceive given situations as they actually exist, but according to a personal scheme of apperception —that is to say, he will perceive situations under the prejudice of his own interests” (p.14). Adler also used the term “neurotic schema” to describe psychopathology within an individual (Ansbacher & Ansbacher, 1956). Beck (1964) introduced the schema concept for working with depression, and more recently (Beck & Freeman, 1990) for the treatment of personality disorders. The use of the terms schema and schema therapy has emerged as central in various sub-disciplines of cognitive
science, as well as various psychotherapy schools (Stein & Young, 1992). Dinkmeyer and Sperry (2000) stated that cognitive therapists, Young (1990) in particular, have described early maladaptive schemas and triggering schemas which are “striking similar to Adlerian formulations of various personality disorders” (p.18), and that the term “schema reflects Adlerian lifestyle convictions” (p.16).

Perhaps Adler’s greatest achievement as a clinician was his contribution to the concept of the style of life or lifestyle. This marquee psychological instrument attempts to capture the client’s phenomenological perspective of the world. In general explanation, a lifestyle is how people view themselves and each other, others in relation to themselves, attitudes, beliefs, morals, values, convictions, and worldly views. Mosak and Maniaci (1999) briefly describe an Adlerian lifestyle as the “individual’s characteristic way of thinking, seeing, and feeling towards life and is synonymous with what other theorists call personality” (p.31).

While Dinkmeyer and Sperry (2000) debate that the terms schema and lifestyle can be used synonymously, Young, Klosko, & Weishaar (2003) states that 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” (p.7). A schema can be positive or negative, adaptive or maladaptive. Schemas can be formed in childhood or later in life. However, many schemas are formed early in life, are continually elaborated on, and then reinforced from later life experiences, even when they are no longer applicable (Young, Klosko, & Weishaar, 2003).

The basic view is that Schemas result from “unmet core emotional needs in childhood.” (Young, Klosko, & Weishaar, 2003 p.9). Schema therapy specifies that these needs are universal for everyone. While these needs are universal for everyone, some individuals will have stronger needs than others. Someone who is psychologically healthy is an individually who has found a
healthy and adaptive way to meet these core emotional needs. Therefore, the goal of Schema therapy is to help individuals find a healthy way to meet their core emotional needs. Schema Therapy recognizes five core emotional needs for all human beings (Young, Klosko, & Weishaar, 2003 p.4-5.):

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 and self-control

Dreikurs and Soltz (1964) have described how children are “excellent observers but make many mistakes in interpreting what they observers” (p.15) of the world around them, and to a large degree, the dynamics of a child’s family are the reality of that child’s entire early world. A child’s nuclear family is not the sole origin or development of Early Maladaptive Schemas. Friends, school, teachers, surrounding environment, and other community groups are other influences that a child learns about the world that may influence schemas. Nonetheless, Schemas developed later in childhood are typically not as pervasive and ingrained as schemas developed from nuclear family experiences. Later in life, individuals find themselves in adult situations that activate their Early Maladaptive Schemas. They are typically experiencing an unresolved conflict or experience from childhood, usually with a parent (Young, Klosko, & Weishaar, 2003).

Adler warned that pampering a child is the most harmful of parenting styles that could lead to a discouraged child and further problems as an adult (Ansbacher & Ansbacher, 1956). Adler described pampering as doing something for children that they could do themselves, and
believed these children become accustomed to getting, and eventually feel neglected when they are denied (Mosak & Maniacci, 1999). Adler noted other problematic parenting styles that are similarly described in Schema Therapy that could lead to the development of Maladaptive Schemas, such as overprotection, overindulgence, over-domination, over-ambition, inconsistency, excessive standards of morality, denigration, and punishments (Mosak & Maniacci, 1999). Schema Therapy (Young, Klosko, & Weishaar, 2003 p.10-11) identifies four early life experiences that cultivate the development of Maladaptive Schemas:

1. *Toxic frustration of needs:* This occurs when the child experiences too little of a good thing. The child’s environment is missing something important, such as stability, understanding, or love. This child may have parents who are over involved in their own lives, such as career focused or separated families, and are therefore under involved in the child’s life. A child who experiences toxic frustration of needs can eventually develop schemas such as Emotional Deprivation or Abandonment through deficits in the early environment.

2. *Traumatization or Victimization:* In this category, the child is harmed or victimized and develops schemas such as Mistrust/Abuse, Defectiveness/Shame, or Vulnerability to Harm.

3. *Too much of a good thing:* The parents often provide too much of something, in which moderation, would have been healthy. The child in this category is rarely purposefully mistreated. Nonetheless, the parents coddle or indulge the child. It is common for a child who is provided too much of a good thing to develop schemas such as Dependence/Incompetence or Entitlement/Grandiosity in adult life, because the child’s core emotional needs for autonomy and/or realistic limits are not met.
Parents in this category are often excessively over or under involved, being either over or under protective. Thus, the child may have an excessive degree of freedom and autonomy without realistic limits, or overprotected without autonomy and unrealistic limit setting.

4. **Selective internalization or identification with significant others**: In this category the child selectively identifies with and internalizes the parent’s thoughts, feelings, experiences, and behaviors. For example, a child who is raised by parents who were abused as children. When this child is abused by his parents, the child chose not to fight back. The child rather became submissive and passive. The child was a victim of abusive behavior, but did not internalize it. The child experienced the feeling of being a victim, but did not internalize the feeling of being the abuser. However, a child may chose to fight back against the abusive parents. The child then identified with the parents by being abusive himself/herself.

Adlerians assume a nonpathological approach and avoid labeling clients with a diagnosis (Corey, 2009). Each individual has a *lifestyle* which is unique to the individual. While there are striking similarities between the Adlerian view of *lifestyle* and Young’s view of a *schema* (Dinkmeyer & Sperry, 2000), Young, Klosko, & Weishaar (2003) have complimented Adlerian therapy by breaking down 18 schemas into five structured categories called, schema domains. These domains are divided by general typology and similar pathology characteristics.

**Schema Domains**

**Domain 1: Disconnection and Rejection**

Individuals who fall within the Disconnection and Rejection domain are typically unable to form secure and satisfying attachments to others. They often have cognitive distortions that
their needs for stability, safety, nurturance, love, and belonging will not be met. Many individuals in this domain have had traumatic childhoods. Another common trait in this domain is a tendency to enter self-destructive relationships or to avoid close relationships altogether. Young and colleagues described “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)” (2003 p.13).

Individuals with the Abandonment/Instability schema experience a perceived instability or unreliability of those available for support and connection. Individuals with this schema anticipate that important people in their life will abandon them, because they are emotionally unpredictable, they will die, or they will leave for someone better (Young, Klosko, & Weishaar, 2003).

Individuals with the Mistrust/Abuse schema have the conviction that given the opportunity, other people will use them for their own selfish gains. For example, they believe that others will abuse, hurt, humiliate, lie to, cheat, and/or manipulate them for their own gains (Young, Klosko, & Weishaar, 2003).

Individuals with the Emotional Deprivation schema have the conviction that their desire/need for emotional connection will not be adequately fulfilled. Young, Klosko, and Weishaar (2003, p.13) identifies three forms of emotional deprivation in Schema Therapy:

1. Deprivation of nurturance: The absence of affection or caring.
2. Deprivation of empathy: The absence of listening or understanding.
3. Deprivation of protection: The absence of strength or guidance from others.
Individuals with the *Defectiveness/Shame* schema have a conviction that they are flawed, bad, inferior, or worthless, and are therefore unlovable to others if exposed. There is typically a sense of shame regarding one’s perceived defects. These perceived flaws may be private (selfishness, aggressive impulses, unacceptable sexual desires) or public (unattractive appearance and/or social awkwardness) (Young, Klosko, & Weishaar, 2003).

Individuals with the Social *Isolation/ Alienation* schema have the conviction feeling as if they do not belong to any group or community. These individuals typically have a sense of being different from or feeling that they do not belong into a social network outside the family (Young, Klosko, & Weishaar, 2003).

**Domain 2: Impaired Autonomy and Performance**

Individuals who fall within the Impaired Autonomy and Performance domain have expectations about themselves and the world that interfere with their ability to differentiate themselves from parental figures and function independently. It is typical that when these individuals were children, their parents did everything for them and overprotected them. While it is less common, it is possible that the parents behaved in the opposite extreme and under protected them as a child, and hardly ever cared for them or watched over them. Either of these extremes leads to autonomy problems. Children’s parents in this domain often undermined their self-confidence and failed to reinforce them for performing adequately outside the home. Unfortunately, these individuals do not possess the skill set to develop their own identities and create their own lives outside of the nuclear family. They are unable to set personal goals, and respectively remain children into their adult lives (Young, Klosko, & Weishaar, 2003).

Individuals with the *Dependence/Incompetence* schema possess a perceived inability of themselves to complete everyday responsibilities without substantial help from others. Many of
these individuals feel unable to manage money, solve practical problems, use good judgment, undertake new tasks, or make good decisions. This schema often presents as learned helplessness (Young, Klosko, & Weishaar, 2003).

Individuals with the Vulnerability to Harm or Illness schema exaggerate fear that a catastrophe will strike at any moment and that they will be unable to cope. (Young, Klosko, and Weishaar, 2003 p.18) suggests fears typically focus on three types of catastrophes:

1. Medical catastrophes: heart attacks, strokes, and fatal diseases such as AIDS.
2. Emotional catastrophes: losing control and/or “going crazy.”

Individuals with the Enmeshment/Undeveloped Self schema are often overly involved with at least one other significant other in their life. This over involvement is typically with a parent, and often hinders their social development and overall individuation. Individuals with this schema often function under the conviction that at least one of the enmeshed individuals could not function without the other (Young, Klosko, & Weishaar, 2003).

Individuals with the Failure schema have the conviction they are fundamentally inadequate to others, and will eventually fail in areas of achievement. These individuals unconsciously seek evidence as self-failures by believing they are unintelligent, inept, untalented, and/or unsuccessful (Young, Klosko, & Weishaar, 2003).

**Domain 3: Impaired Limits**

Individuals with schemas in this domain have difficulties respecting the rights and/or cooperating with others. They also struggle to keep commitments or meet long term goals. They lack relationship reciprocity and self-discipline. Thus, persons in this domain present as selfish, spoiled, irresponsible, and/or narcissistic. Not surprisingly, these individuals typically grew up
in families that were overly permissive and indulgent, and as children were not required to
follow rules that everyone else had to or develop self-control. They therefore as adults, often
lack the ability to manage their impulse control (Young, Klosko, & Weishaar, 2003).

Individuals with *Entitlement/Grandiosity* schema function under the conviction that they
are superior to others, and therefore are entitled to special rights and privileges. Individuals with
this schema act as if the reciprocal portion of relationships does not pertain to them. They often
have an apathetic lifestyle with little concern on their effect on others around them. They often
maintain an exaggerated focus on superiority in order to maintain or achieve power. They often
present as overly demanding, dominating, and lack empathy (Young, Klosko, & Weishaar,
2003).

Individuals 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. In a
sense, these individuals “wear their emotions on their sleeves,” and do not regulate their
expressions of their emotions and impulses. A mild version of this schema would be one who
avoided most conflict or responsibility (Young, Klosko, & Weishaar, 2003).

**Domain 4: Other-Directedness**

Individuals in this domain place a disproportionate importance on meeting the needs of
others and virtually ignore their own needs. These individuals typically behave in this manner to
gain approval, maintain emotional connection with, or avoid retaliation from others. Individuals
in this domain tend to focus exclusively on the reactions of others and ignore their own needs.
They often lack insight and awareness of their own emotions. As children, these individuals
were restricted from the autonomy of their own natural inclinations. Therefore, as adults, instead
of being self-directed, they are directed externally from the cues of others. A typical family
setting fosters conditional acceptance first, and independence a far second. Children are taught
to restrain important aspects of themselves in order to obtain love or approval. In many of these
families, parents model that their own emotional needs and/or social appearances are superior to
the unique needs of the child (Young, Klosko, & Weishaar, 2003).

Individuals with the Subjugation schema experience an excessive surrendering of control
to others, because they feel coerced. Individuals with Subjugation schema possess a conviction
that their own needs and emotions are not important. Young, Klosko, and, Weishaar (2003, p.
19-20) has two major forms of Subjugation:

1. Subjugation of needs: suppressing one’s preferences or desires.
2. Subjugation of emotions: suppressing one’s emotional responses, especially anger.

The behavioral function of Subjugation is typically to avoid anger, retaliation, or abandonment. Subjugation schema typically presents as excessive compliance and an eagerness
to please (pleasing lifestyle), while hypervigilant to the feeling of being trapped. Individuals
with the Subjugation schema live with unmeet needs and emotions, which often leads to a
buildup of anger. This anger often manifests in maladaptive symptoms such as passive-
aggressive behavior, uncontrolled temper outbursts, psychosomatic symptoms, or withdrawal of
affection (Young, Klosko, & Weishaar, 2003).

Individuals with the Self-Sacrifice schema voluntarily meet the needs of others at their
own expense and self gratification. These individuals behave in a way that is consistent with
sharing others pain, avoiding guilt, gain self-esteem, or to maintain an emotional connection with
someone they deem as emotionally needy. The schema often results from an acute sensitivity to
the suffering of others and involves the sense that one’s own needs are not being met and may
lead to feelings of resentment. This schema has similarities with the 12-step concept of codependency (Young, Klosko, & Weishaar, 2003).

Individuals with the Approval-Seeking/Recognition-Seeking schema have a higher appreciation for gaining approval or recognition from others over developing a genuine sense of self. Consequently, their self-esteem is excessively reliant on other’s reactions rather than their own actions. Since this schema is excessively dependent on other’s reactions and seeking external approval, these individuals often have an excessive preoccupation with social status, appearance, money or any means which result in gaining approval or recognition. Many major life decisions are made for the purposes of gaining others approval, and therefore are inauthentic and often ultimately unsatisfying (Young, Klosko, & Weishaar, 2003).

Domain 5: Overvigilance and Inhibition

Individuals in this domain have a tendency to suppress their spontaneous feelings and impulses. They often strive to uphold rigid and self-internalized rules around their own performances. Meeting these internalized rules usually comes at the expense of overall happiness, self-expression, relaxation, close relationships, and good health. A typical childhood origin of this domain is one who was repressed, possibly with strict rules and unrealistic expectations, self-control and self-denial trumped spontaneity and pleasure. These children were not encouraged to play, experience free-will, or happiness. They were instead taught to be hypervigilant to negative life events and were encouraged to view life in a negative and unwelcoming perception (Young, Klosko, & Weishaar, 2003).

Individuals with the Negativity/Pessimism schema possess a pervasive and lifelong focus on the negative aspects of life (e.g., pain, death, loss, disappointment, conflict, betrayal) while minimizing the positive aspects. These individuals typically endure an exaggerated conviction
that something will inevitably go seriously wrong in a major area of their life, such as work, financial, or interpersonal situations. Therefore, these individuals have an unreasonable fear of making decisions that may potentially lead their collapse or being stuck in an unfavorable situation. Since these individuals live with a hesitating attitude, they are often characterized by worry, apprehension, hypervigilance, complaining, and indecision (Young, Klosko, & Weishaar, 2003).

Individuals with the Emotional Inhibition schema tend to constrain their spontaneous actions, feelings, and communication. The purposefulness of this emotional constraint is typically to prevent being criticized or losing control of their impulses. Young, Klosko, & Weishaar (2003, p.21) suggest there are four main areas of inhibition that include:

1. Inhibition of anger
2. Inhibition of positive impulses (e.g., joy, affection, sexual excitement, playfulness)
3. Difficulty expressing vulnerability
4. Emphasis on rationality while disregarding emotions. These individuals often present as flat, constricted, withdrawn, or cold

Individuals with the Unrelenting Standards/Hypercriticalness schema have a conviction that they must strive to meet very high internalized standards, typically to avoid disapproval or shameful feelings. Individuals with this schema typically have feelings of constant pressure and hypercriticalness towards oneself and others. There must be significant impairment to the individual’s health, self-esteem, relationships, or experience of pleasure to be considered an Early Maladaptive Schema (Young, Klosko, & Weishaar, 2003). According to Young, Klosko, & Weishaar (2003, p.21), individuals within this schema typically presents in one of these three categories:
1. **Perfectionism**: They need to do things right, excessive attention to detail, or underestimating one’s level of performance.

2. **Rigid rules and “shoulds”**: Rigid rules and “shoulds” in too many areas of life, including unrealistically high moral, cultural, or religious standards.

3. **Preoccupation with time and efficiency**: One who excessively is preoccupied with balancing time and efficiency to the point it has a significant impairment on one’s life.

Individuals with the *Punitiveness* schema possess the conviction that people should be harshly punished for making mistakes. These individuals have a tendency to become angry and intolerant with those people (including self) who do not meet one’s standards. These individuals have extreme difficulties forgiving others for mistakes, because they are reluctant to consider extenuating circumstances, allow for human imperfection, or to take into account another person’s viewpoint (Young, Klosko, & Weishaar, 2003).

Adlerian Therapy and Schema Therapy have noticeable similarities in the way their initial assessments are performed. The orientations adhere to different terminology, but both place significant importance on performing an extensive life history of the client which leads up to the presenting problems. Adlerian Psychology appears to be a foundation in which Schema Therapy has redefined for its’ Assessment and Education Phase, particularly the use of the *focused life history* forms. Nonetheless, Schema Therapy utilizes more inventories which focus solely on identifying the individual’s Maladaptive Schemas.
Assessment and Education Phase

Assessing Suitability

During the assessment and education phase, the therapist is assessing suitability of the patient for schema therapy. Schema therapy is not appropriate for everyone. Schema therapy is most appropriate for those who have life-long, enduring, and pervasive patterns. For some individuals, it will become appropriate later in therapy, after acute crises and symptoms have improved, but not earlier. Young, Klosko, & Weishaar (2003, p.71) have identified the following list of indications which schema therapy may not be suitable or may need to be postponed:

1. The patient is in a major crisis in some life area
2. The patient is psychotic.
3. The patient has an acute, relatively severe, untreated Axis I disorder requiring immediate attention.
4. The patient is currently abusing alcohol or other drugs at a moderate to severe level.
5. The presenting problem is situational or does not seem to be related to a life pattern or schema.

While the Schema Therapy assessment is well structured, it is not formulaic. Instead, the therapist develops clinical hypotheses based on presenting information and adjusts these hypotheses as more information is available. The therapist identifies life patterns, schemas, coping styles, and temperament to gradually formulate a schema-focused case conceptualization.

Young, Klosko, & Weishaar (2003, p.63) state that the Assessment and Education Phase of Schema therapy has six major goals:
1. Identification of dysfunctional life patterns.

2. Identification and triggering of Early Maladaptive Schemas.

3. Understanding the origins of schemas in childhood and adolescence.

4. Identification of coping styles and responses.

5. Assessment of temperament.

6. Putting it all together: the case conceptualization.

The schema therapist begins with an initial evaluation, assesses the individual’s presenting problems, goals for therapy, and evaluates the individual’s suitability for schema therapy. Next, the therapist takes a life history, which assists in identifying dysfunctional life patterns that prevent the individual from meeting basic emotional needs and goals. These patterns are often long-term, self-perpetuating cycles in relationships and at work that lead to dissatisfaction and symptomatology. The therapist explains the schema model and explains that they will, together, work to identify the patient’s schemas and coping styles. During this phase, patients complete questionnaires for homework assignments, and then the results are discussed together in sessions. The therapist uses experiential techniques, especially imagery to access and trigger schemas. Together, they try to link schemas to their childhood origins and to the presenting problems. The therapist pays close attention to the therapeutic relationship, gauging how the patient’s schemas and coping styles present appear in therapy. Finally, the therapist observes and assesses the patient’s temperament (Young, Klosko, & Weishaar, 2003).

During the course of assessment, patients begin to recognize, understand, and analyze how their schemas, their childhood origins, and the self-destructive patterns have recurred throughout their lives. Patients begin to identify the coping style they have developed to deal with their schemas, surrender, avoidance, or overcompensation. They also analyze how their
individual temperaments and early life experiences predisposed them to develop their individual coping styles. They then link their schemas to their current presenting problems, giving them a meaningful and purposeful connection between childhood to the present time (Young, Klosko, & Weishaar, 2003).

The Assessment Phase is both intellectual and emotional by in nature. Patients identify schemas through the use of questionnaires and logical analysis, but they also feel their schemas emotionally through the use of experiential techniques such as imagery work. A decision on the hypothesis of a suspected schema is based largely on what “feels right” or “fits” to the patient. A correctly identified schema typically resonates emotionally for the patient (Young, Klosko, & Weishaar, 2003).

The time to complete the Assessment Phase is variable depending on the individual. Relatively straightforward cases may only require five sessions. However, patients who have an overcompensating or avoidant coping style may require more time. Nonetheless, it is important not to rush the Assessment Phase, as accurate schema identification guides interventions, enhances the therapeutic relationship by helping the patient feel understood, and anticipates likely areas of difficulty during the Change Phase. It is equally important to have accurate identification of the patient’s coping styles in the case conceptualization. Does the patient primarily surrender to, avoid, or overcompensate for schemas? Typically, most patients use a mixture of coping styles, but there usually is a tendency to have a dominant coping mechanism among the styles (Young, Klosko, & Weishaar, 2003).

It is extremely important that the therapist does not assume the presence of a schema based solely on the simplistic analysis of childhood experiences, because two people may have similar childhood circumstances, yet result in different schemas because of different life
experiences and/or interpretations of these experiences. It is equally important for the therapist to validate adaptive value of the patient’s coping style. The patient developed the coping style for a reason, to cope with difficult childhood situations. However, the coping style is probably maladaptive in the adult world, where the patient has more choices and is no longer at the mercy of parental mistreatment or neglect (Young, Klosko, & Weishaar, 2003).

By the end of the Assessment Phase, the therapist completes the Schema Therapy Case Conceptualization Form. This form includes the patient’s schemas, links to the presenting problems, schema triggers, hypothesized temperamental factors, developmental origins, core memories, core cognitive distortions, coping behaviors, modes, the effects of schemas on the therapeutic relationship, and change strategies (Young, Klosko, & Weishaar, 2003).

The therapist is specific when defining the presenting problems and treatment goals. For example, when stating a presenting problem, instead of saying, “The patient is having trouble choosing a career,” the therapist says, “The patient negates potential career options and procrastinates looking for work;” or, instead of saying, “The patient has relationship difficulties,” the therapist says, “The patient repeatedly chooses partners who are withholding and aloof” (Young, Klosko, & Weishaar, 2003, p.70).

Focused Life History

As stated earlier, perhaps Adler’s greatest contribution was his idea of lifestyle or style of life. In Adlerian psychology, “the term lifestyle refers to a person’s basic orientation to life” (Dinkmeyer & Sperry, 2000, p.33). Whereas other theorists have used terms such as psyche, personality, ego, or self, Adlerians have used the phrase style of life (Ansbacher & Ansbacher, 1956; Carlson, Watts, & Maniaci, 2006; Powers & Griffith, 1987). “The style of life, often shortened to life style, is that which creates meaning and value” to one’s life (Carlson, Watts, &
Ansbacher and Ansbacher (1956) refer to the term as a dynamic state, rather than a rigid or static entity. A person’s lifestyle is “based on one’s private logic, develops out of one’s life plan, and is powered by the fictional goal one established for oneself” (Dinkmeyer & Sperry, 2000, p.33). The lifestyle serves many purposes, however, Carlson, Watts, & Maniacci (2006) have highlighted that the lifestyle provides humans with a guide, biological limiter, and a predictor or future behavior.

In order to understand the patient’s lifestyle, Adlerian therapists conduct a lifestyle analysis or lifestyle interview. The interview is a semi-structured process for understanding the developmental influences on the style of life. A family constellation is taken, particularly honing in on the family milieu and dynamics, significant figures, birth order, perceptions of self, problems as a child, childhood fears, coping styles, and other significant events as well as early recollections are combined to formulate the lifestyle assessment (Carlson, Watts, & Maniacci, 2006; Powers & Griffith, 1987).

Schema Therapy’s life focused history has many parallels and appears to build up Adler’s lifestyle analysis. Nonetheless, Schema therapy’s life focused history is more structured, and the therapist tries to determine whether the patient’s presenting problems are situational or whether they reflect a life behavioral pattern. The therapist looks for previous schema activations in the patient’s life. The therapist is assessing for patterns that may emerge with similar triggering events, cognitions, emotions, and behaviors over time and across situations. Relationship histories, school and/or work difficulties, and other life struggles provide insight to schemas. The therapist is also assessing possible coping styles of surrender, avoidance, and overcompensation of the patient, and explores how he/she has used the coping style(s) with their schemas in the past. The understanding of coping styles is important, because patient’s react
differently depending on how they are coping. When patients surrender to a schema, they often tend to reenact it as how they would as a child. They experience similar thoughts and feelings as when they were a child, and therefore they behave in a similar fashion. However, when patients use avoidance as a coping strategy, it appears as if they are fleeing from the schema. Patients who utilize schema avoidance typically deny, escape, minimize, or detach from the schema. On the other hand, when patients use overcompensation to cope with their schema, the patient appears to be fighting back with the schema. These patients use tactics to counterattack, compensate for, or externalize the schema. People’s individual coping styles are the result of both their temperament and parental modeling. It is critical that the therapist understands the patient’s coping styles, because over a lifetime, coping strategies are a generalized way of viewing and interacting with the world. Therefore, for the therapist to understand the patient, the therapist must not only uncover the patient’s schemas, but also the coping strategies (Young, Klosko, & Weishaar, 2003).

Schema assessments serve many salient functions in schema therapy. The assessments help guide the sessions in a structured manner while covering and helping the patient understand his/her schemas, its origins, and thus beginning the healing process.

**Life History Assessment Forms**

The *life history* assessment forms provide a comprehensive assessment of the patient’s current problems, symptoms, family history, images, cognitions, relationships, biological factors, and significant memories and experiences. The inventory is lengthy and can be given as homework, which can also save significant therapy time. It is also important to note that some patients who do not report abuse in the interview will do so on the questionnaire. Some patients
feel more comfortable reporting the abuse in writing versus verbally informing the therapist (Young, Klosko, & Weishaar, 2003).

**Young Schema Questionnaire**

The Young Schema Questionnaire (YSQ-L2) is a 205 question self-reporting measure to assess schemas. Patients rate themselves on how well each item describes them on a 6-point Likert scale. The YSQ-L2 is usually taken home and completed after the first or second session. While the names of the schemas are not on the questionnaire itself, they are grouped into categories. The therapist does not usually compute a total score in order to interpret the results. Instead, the therapist looks for each schema separately, circling high scores (usually 5’s and 6’s) and draws attention to potential patterns. In one or two sessions, the therapist and patient review the completed questionnaire together, with the therapist asking questions about items that were rated highly. If a patient has three or more high scores (rated 5 or 6) on a particular schema, that schema is usually relevant to the patient and worthy of exploration. The therapist uses the high-scoring items to encourage the patient to discuss each relevant schema by asking questions. The therapist will ask, “Can you tell me more about how this statement relates to your life?” Exploring two high scoring items from each relevant schema with the patient is usually sufficient to identify or dismiss the essence of a schema. The therapist then educates the patient on the name and meaning of each high-scoring schema in laymen’s terms. The therapist will also encourage the patient to read more about the schema in “reinventing your life” (Young, Klosko, & Weishaar, 2003).

**Young Parenting Inventory**

The Young Parenting Inventory (YPI) is one of the primary methods used to identify the childhood origins of schemas. The YPI and the YSQ are designed to supplement each other.
The YPI is designed to identify likely origins for schemas that score high on the YSQ. Similar to the YSQ, the YPI uses a 6-point Likert scale and is grouped by schemas. The YPI is typically given as homework as well, but typically around the fifth or sixth session when discussing the origins of schemas. The YPI consists of 72 questions in which respondents separately rate parental figures on a variety of behaviors which Young (year) hypnotizes contribute to the development of the patient’s Early Maladaptive Schemas. The YPI is flexible in nature, as the questionnaire can easily adapt to additional parental figures, such as stepparents, grandparents, or other parent substitutes, by simply adding additional columns to the questionnaire. One should not misinterpret the word “parenting” in the YPI as measuring the patient’s parent’s schema, the YPI instead reflects childhood environments that are likely to shape the development of specific schemas. Nonetheless, it is possible for a patient to experience a common childhood experience that is associated with a particular schema, but not develop the anticipated schema. Young describes three possible reasons for this: (1) the patient’s temperament prevented the schema from developing; (2) one parent or significant other in the child’s life compensated for the other; or (3) the patient, a significant person, or an event later in life healed the schema (Young, Klosko, & Weishaar, 2003).

Since the YSQ and the YPI are designed to complement each other, it is important to not only be vigilant to inventory parallels, but equally important are the discrepancies. For example, if a patient strongly endorses items on the YPI that reflect the typical origins of a schema, Young frequently observes that the patient has that schema, even if the patient rated the same schema low on the YSQ. A likely explanation for this phenomenon is that patients are often able to accurately identify what their parents’ behavior was like even though they themselves are out of
touch with their own emotions. This scenario is more common with high schemas in avoidance or overcompensation (Young, Klosko, & Weishaar, 2003).

Scoring the YPI is also similar to the YSQ, the therapist circles and considers a high probability of clinical significance to all scores that are rated 5 or 6 for either parental figure. However, unlike the YSQ, only one high score on a particular schema is required to be potentially significant. While more high scores in one schema increases relevance, any high scoring item on the YPI can be meaningful in understanding schema origin. An example of this is if a patient indicates sexual abuse from a parent on the YPI, it is likely that this patient will have a Mistrust/Abuse schema, even if the patient rated other origins of the same schema very low. Lines 1 through 5 are also scored uniquely and are of particular importance. These first 5 lines measure Emotional Deprivation and are scored in reverse. Therefore, low scores indicate high significance for an origin in Emotional Deprivation (Young, Klosko, & Weishaar, 2003).

After the therapist has reviewed the patient’s YPI scores and compared them to the YSQ, the patient and therapist review the scores together. They discuss any high-scoring items and the therapist encourages the patient to expand on high scoring items by giving childhood or adolescent examples. The therapist also asks for clarification on any inconsistencies between the two inventories in an attempt to both clarify patient’s schemas and their origins. This discussion assists the therapist by gathering a full and accurate picture of how each parent contributed to the development of the patient’s schemas. The therapist also explains to the patient the relationship between each origin and the corresponding schema, and how the childhood origin and schema may be linked to the patient’s presenting problems (Young, Klosko, & Weishaar, 2003).
Young-Rygh Avoidance Inventory

The Young-Rygh Avoidance Inventory is a 41-item questionnaire that assesses schema avoidance. It includes statements such as, “I watch a lot of television when I’m alone,” “I try not to think about things that upset me,” “I get physically ill when things aren’t going well for me.” As with the other inventories, the Young-Rygh Avoidance Inventory has individuals respond to a 6-point Likert scale, and the therapist is not especially concerned with the total score, but rather high-scoring items. Nonetheless, unlike other inventories, a high score on the Young-Rygh Avoidance Inventory does indicate a general pattern of schema avoidance. The inventory is not schema specific. Yet, an avoidant coping style is often a pervasive trait that can be used to avoid any schema (Young, Klosko, & Weishaar, 2003).

Young Compensation Inventory

The Young Compensation Inventory is a 48-item questionnaire that assesses schema overcompensation. It includes items such as “I often blame others when things go wrong,” and “I agonize over decisions so I won’t make a mistake,” and “I dislike rules and get satisfaction from breaking them.” As with the other inventories, the Young Compensation Inventory has individuals respond to a 6-point Likert scale, and the therapist is not especially concerned with the total score, but rather high-scoring items are again discussion points (Young, Klosko, & Weishaar, 2003).

Imagery Assessment

Thus far in the assessment process, the Schema therapist has completed the life history and reviewed completed questionnaires with the patient. Together, the therapist and patient are beginning to understand the patient’s schemas and coping styles. The next step is to trigger the patient’s schemas in a therapeutic setting so both the therapist and patient can experience them
together. This is typically accomplished through the use of imagery. Imagery is a powerful assessment tool, and can often be the most effective way to identify schemas (Young, Klosko, & Weishaar, 2003). The goals of imagery for assessment are:

1. To identify and trigger the patient’s schemas.
2. To understand the childhood origins of the schemas.
3. To link schemas to presenting problems.
4. To help the patient experience emotions associated with the schemas.

Adlerian therapists use a metaphoric and projective technique called Early Recollections, as an assessment tool as well that has many similarities to the use of Imagery in Schema therapy. Adlerian therapists will ask for early memories before the age of 10 (Corey, 2009; Griffith & Powers, 2007; Mosak & Pietro, 2006). The rationale behind acquiring a memory before the age of 10 is most people do not have continuous memory and cannot remember the sequence of events, therefore, the client has to patch or fill in the missing pieces of the story (Mosak & Pietro, 2006). These patches in the early recollection give the therapist ideas about the individual’s current perceptions. Adler reasoned that out of millions of early memories clients might select those that disclose their private logic, that is how they see the world, what their life goals are, what motivates them, what they value, as well as mistaken goals and convictions (Corey, 2009). Bitter, Christensen, Hawes, & Nicoll (1998) support the use of early recollections for assessing convictions about self, others, life, coping patterns, but also adds early recollections can be useful at assessing an individual’s strengths, assets, interfering ideas, and client’s stance on the therapeutic alliance.

Imagery is first explained during the *assessment phase* to the patient by providing convincing rationale for imagery work. It is explained that imagery will help them feel their
schemas, understand the childhood origins of their schemas, and connect their schemas to their current presenting problems. After patients have received this brief rationale, they are asked to close their eyes and allow an image to appear in their mind. The image should not be forced, but allowed to let it appear on its own. Once patients have an image, they are asked to describe it to the therapist, out loud and in the present tense (Young, Klosko, & Weishaar, 2003).

It is important for the patient to become comfortable early with imagery work, as it is a fundamental experiential technique later in therapy during the change phase. Thus, the example below is a safe way to introduce imagery to patients which will later be expounded upon.

The following is an exercise developed by Young, Klosko, & Weishaar (2003, p.80) for therapists attending workshops on schema therapy:

1. Close your eyes. Picture yourself in a safe place. Use pictures, not words or thoughts.
   Let the image come on its own. Notice the details. Tell me what you are picturing.
   What do you feel? Is there someone with you, or are you alone? Enjoy the relaxing, secure feeling in your safe place.

2. Keep your eyes close and wipe out that image. Now picture yourself as a child with one of your parents in an upsetting situation. What do you see? Where are you? Notice all the details. How old are you? What’s happening in the image?

3. What do you feel? What are you thinking? What does your parent feel? What is your parent thinking?

4. Carry on dialogue between you and your parent. What do you say? What does your parent say? (Continue until dialogue reaches a natural conclusion.)

5. Consider how you would like your parent to change or be different in the image, even if it seems impossible. For example, do you wish your parent would give you more freedom?

6. How does your parent react? What happens next in the image? Keep the image going until the scene ends. How do you feel at the end of the scene?

7. Keep your eyes closed. Now intensify the feeling you have in this image as a child. Make the emotion stronger. Now, keeping the emotion in your body, wipe out the image of yourself as a child and picture an image of a situation in your current life in which you have the same or a similar feeling. Don’t try to force it; let it come on its own. What’s happening in the image? What are you thinking? What are you feeling? Say it out loud. If there is someone else in the image, tell that person how you would like him or her to change. How does the person react?

8. Wipe out the image and return to your safe place. Enjoy the relaxed feeling. Open your eyes.

It is important that patients start and end in a safe place. Typically the patient begins with an upsetting image from the patient’s childhood and then works forward by linking this image to an upsetting image from the patient’s current life. Nonetheless, imagery exercises may proceed in other ways. For example, if a patient enters a session already upset about a current situation, that situation can be used as the image to begin with, and then work back in time when as a child they felt the same way (Young, Klosko, & Weishaar, 2003).

Throughout the assessment process, the therapist educates the patient about the schema model. This is typically done through discussions, assigned readings, and self-observation. It is common practice for a schema therapist to assign Reinventing You Life (Young and Klosko,
1994) to patients to help them learn more about their schemas, which are referred to as “life-traps” in the book. The book presents extensive case examples, which patients can relate to and generate discussions about their schemas and presenting problems with the therapist (Young, Klosko, & Weishaar, 2003).

After the assessment and education phase has been completed, the therapist and patient move into the change phase. The change phase incorporates cognitive, experiential, behavioral, and interpersonal strategies to modify schemas, coping styles, and modes. Similar to Adlerian therapists, Schemas therapists typically begin with cognitive techniques.

**Cognitive Strategies**

Similar to Adlerian Psychology, the primary stance or style that a schema therapist takes throughout the sessions is “empathic confrontation” or “empathic reality testing.” Empathic confrontation means that the therapist empathizes with the reasons for patients possessing the beliefs they have, because their beliefs are based on their early childhood experiences, while simultaneously confronting the fact that their beliefs are distorted and lead to unhealthy life patterns that patients must change in order to enhance their quality of life (Young, Klosko, & Weishaar, 2003). Therapists acknowledge to patient’s that their schemas seem fitting to them, because they have lived their entire lives in a way which has verified their schemas, and have developed adopted certain coping styles, because if was the only way to survive their childhood experiences. These schemas and coping styles were adaptive in early childhood, but now are maladaptive in their adult lives. A therapeutic stance of empathic confrontation acknowledges the past while distinguishing the realities of the past from the realities of the present. With empathic confrontation, the therapist strives for the optimal balance between empathy and reality-testing that will enable patients to progress. When the therapist is successful in this
endeavor, patients feel truly understood and affirmed, perhaps for the first time in their lives (Young, Klosko, & Weishaar, 2003).

Cognitive strategies assist the patient develop a healthy voice to dispute and eventually override the schema, strengthening the patient’s Healthy Adult mode. The therapist helps the patient build a logical and rational case against the schema. This is new territory for patients, who have not questioned their schemas up until this point. They have accepted their schemas as absolute truths in their lives. Cognitive strategies help patients step outside the schema and evaluate its authenticity. Patients may realize for the first time their schema is inaccurate, untrue, or greatly exaggerated. When cognitive strategies are effective, patients gain an enhanced understanding of how distorted the schema actually is. They have gained psychological distance from the schema and no longer view it as absolutes, thus creating insight into how the schema affects and alters their perceptions. Successfully treated patients have the ability to realize when a schema is triggered in their lives outside of therapy, and are able to counter the schema by utilizing cognitive techniques. Even though patients may still feel as though the schema is true, but have the cognitive ability to challenge and counter. They have an increased intellectual awareness that the schema is false (Young, Klosko, & Weishaar, 2003).

The therapist and patient begin the change phase by agreeing that the schema is open to question, a hypothesis to be tested through logical and empirical analyses. They examine the evidence supporting and refuting the schema, the evidence the patient has used to uphold the schema, and then they also find alternative interpretations of these same events. They also conduct debates between the “schema side” and the “healthy side,” listing the advantages and disadvantages of the patient’s coping styles. All this work is eventually placed on Schema Flash Cards, a tool for whenever the patient’s schema is triggered. Eventually, patients practice
responding to schemas on their own using a Schema Diary Form (Young, Klosko, & Weishaar, 2003).

**Cognitive Techniques**

Both Adlerian Psychology and Schema Therapy utilize an arsenal of cognitive techniques to encourage positive movement and facilitate change. Carlson and Slavik (1997, p.4) state “Good adult therapy and involved technique become a way of aiding people in understand their goal, their private logic, their methods of achieving the goal, and possible adverse consequence of their goal or methods.” Carlson and Slavik (1997) also highlight that therapists need to remain flexible and select the appropriate technique to meet the client’s needs, and not become rigid and over-reliant on a few techniques.

Cognitive Techniques in Schema Therapy include the following:

1. Testing the validity of a schema
2. Reframing the evidence supporting a schema
3. Evaluating the advantages and disadvantages of the patient’s coping styles
4. Conducting dialogues between the “schema side” and the “healthy side”
5. Constructing schema flash cards
6. Filling out Schema Diary forms

**Testing the Validity of the Schemas**

Similar to how Adlerian therapist’s and the client approach *convictions*, the Schema therapist and the patient approach the Schema as the hypothesis to be tested. Together, they test the validity of a schema by examining the objective evidence for and against the schema. The process is similar to testing the automatic thoughts in cognitive therapy, except in schema therapy, the therapist uses the patient’s entire life as empirical data and not just the presenting
circumstances (Young, Klosko, & Weishaar, 2003). Together, they create a list of evidence from the past and present that supports the schema, and then they create another list of evidence from the past and present that refutes the schema. Patients usually find it easy to compose the list supporting the evidence, because they have been rehearsing it their entire lives, and therefore, *acting as if* the Schema is true. It feels natural and familiar for them. However, patients typically find it extremely difficult to compose the list which refutes the schema. The therapist typically has to guide and assist a great deal with this list, because they do not believe the evidence against the schema. They have spent their entire lives either ignoring or downplaying this evidence, and therefore find it difficult to list. After writing down how they negate evidence, patients can reclaim the evidence against the schema. The therapist shows how invalidating the evidence against the schema is simply another form of schema perpetuation (Young, Klosko, & Weishaar, 2003).

**Reframing the Evidence Supporting the Schema**

The next step is to take the list of evidence supporting the schema and to generate alternative explanations for what happened. The therapist takes the evidence the patient views as proving to the schema and reattribute’s them to other causes. The goal is to discredit the evidence supporting the schema (Young, Klosko, & Weishaar, 2003).

**Evidence from the Patient’s Early Childhood**

The therapist discounts early childhood experiences as reflecting pathological family dynamics, including poor parenting, rather than the truth of the schema. The therapist points out that certain behaviors would not have been acceptable in healthy families. The therapist and patient consider the psychological well-being and character of the parents and other family members. The therapist points out that often parents assign roles that meet the parent’s need, and
not the child’s. These roles do not reflect the inherent flaws in the child, but of those of the
parent’s. The goal is to have patients stop viewing their early childhood experiences as proof of
their schemas, and instead understand why they possess the perceptions they have (Young,
Klosko, & Weishaar, 2003).

Evidence from the Patient’s Life since Childhood

The therapist discounts experiences since childhood that support the schema by
attributing them to schema perpetuation. The coping styles patients learned in childhood have
carried their schemas forward into their adult lives. Therefore, the therapist notes that, because
of their schema-driven behavior, patients have never given their schemas a fair test (Young,
Klosko, & Weishaar, 2003).

Evaluating the Advantages and Disadvantages of the Patient’s Coping Responses

The therapist and patient examine each schema and their coping responses individually
and list advantages and disadvantages for them. Together, they have already identified the
patient’s coping styles in the Assessment and Education Phase. Now the goal is for patients to
recognize the self-defeating nature of their coping styles, and realize if they replaced these
coping styles with healthier behaviors, they could live a happier life. The therapist also reminds
the patient that these coping styles were adaptive as children, but maladaptive as adults (Young,
Klosko, & Weishaar, 2003).

Conducting Dialogues Between the “Schema Side” and the “Healthy Side”

Conducting dialogues between sides is similar to using the *acting as if* technique. Clients
go through life *as if* their convictions, schemas, or personalities are factual. There are several
variations of this technique, but one role playing *as if* their presenting problem was not there may
be the most effective (Carlson, Richard, & Maniacci, 1997). Schema therapy uses a similar
cognitive technique where patients learn to conduct dialogues between their “schema side” and their “healthy side.” This cognitive technique is achieved through adapting the Gestalt “empty chair” technique, the therapist instructs the patient to switch chairs as they role play two side (Young, Klosko, & Weishaar, 2003).

In Schema Therapy, one chair represents the schema side, and the other chair is the patient’s healthy side. When introducing this Gestalt influenced empty chair technique, the therapist will normally play the healthy side and the patient plays the schema. Up to this point, the patient has little to zero experience expressing the healthy side, thus having the therapist role model the healthy side can help introduce this technique, and help the patient begin developing insight. Eventually the patient and therapist can switch roles, having the patient take over their healthy side, and the therapist acting as a coach. When the patient plays both roles, the patient moves back and forth between the two chairs, representing both the schema side and the healthy side. The therapist continues the exercise until the healthy side has the last word. “The goal is for patients to learn how to play the healthy side on their own, naturally and automatically” (Young, Klosko, & Weishaar, 2003, p.100).

**Constructing Schema Flash Cards**

Schema flash cards are used to help summarize healthy responses to specific schema triggers. The therapist and patient write schema flash cards together, and patients carry the flash cards around and read them when their schemas are triggered. Patients can read flash cards before going into a situation to help prepare them for an event. Reading their individual schema flash cards offers powerful evidence and arguments against the schema and provides patients with continual rehearsals of rational responses (Young, Klosko, & Weishaar, 2003).
Filling Out Schema Diary Forms

The Schema Diary is a more advanced technique than the flash cards, and is introduced later in treatment after the patient has become proficient at using flash cards. Flash cards are created with the therapist’s input ahead of time to thwart a specific triggered schema, and the patient reads them as needed before and during an event. The Schema Diary on the other hand, has patients create their own healthy responses as their schemas are triggered in the course of their daily lives. The Schema Diary asks patients to identify trigger events, emotions, thoughts, behaviors, schemas, healthy views, realistic concerns, overreactions, and healthy behaviors. Patients are instructed to carry copies of the Schema Diary form outside of therapy and utilize them when a schema is triggered in order to work through the problem and arrive at a healthy solution (Young, Klosko, & Weishaar, 2003).

Adlerian Psychology and Schema Therapy both utilize the use of imagery as an experiential technique. There are subtle differences with the two styles. Adlerians use Early Recollections, which are recalled memories before the age of ten, to help understand the style of life and to gain insight on convictions. Schema Therapy aims to trigger emotional responses and to reparent the patient’s unmet childhood needs.

Experiential Strategies

Experimental techniques aim to trigger the emotions connected to Early Maladaptive Schemas and to reparent the patient in order to heal these emotions and partially meet the patient’s unmet childhood needs. For many patients, experiential techniques seem to be the most effective and elicit the most profound change. It is through experiential work that patients transition from knowing intellectually that their schemas are false to believing it emotionally. Cognitive and behavioral techniques draw their power from the accumulation of small changes
over time with repetition. Whereas experiential techniques are more dramatic, and tend to draw their power from a few deeply convincing corrective emotional experiences (Young, Klosko, & Weishaar, 2003).

**Imagery**

Schema Therapy’s primary experiential assessment technique is imagery. Since patients were introduced to imagery during the *education and assessment phase*, patients do not require an extensive rationale for doing imagery work. Nonetheless, a brief reintroduction to imagery is given to patients. Imagery is a powerful technique which allows both the therapist and patient to experience the patient’s schemas in the office, by triggering them through imagery. Most importantly, imagery allows patients to emotionally link the origins of their early maladaptive schemas to current presenting problems (Young, Klosko, & Weishaar, 2003).

The therapist generally begins by asking patients to “let an image float to the top of their mind.” Imagery should not be confused with free association, in which one thought leads to another. Rather, with therapist assistance, imagery is like watching a movie about yourself in your own mind. In addition, patients are to experience, to become a part of the movie, and live through the events that unfold. Therapists ask questions such as, “What are you seeing?”, “What are you hearing?”, “Can you see yourself?” “What is the look on your face?” Once the image is distinct, the therapist explores the thought and emotions of everyone and everything, “the characters,” in the image. The therapist ends the imagery session by asking patients to open their eyes and asking open ended questions about their experience, such as: “What was the experience like for you?” “What did the images mean to you?” “What were the themes?” “What schemas are related to those themes?” (Young, Klosko, & Weishaar, 2003).
Initially, imagery sessions start and end with an image of a safe place. This is especially true for patients with severe trauma histories. Starting in a safe place is a non-threatening way of introducing imagery before moving into more significant, emotionally-charged material. It is equally important to end in a safe place. Enough time should be allocated for patients to calm down and fully discuss imagery sessions. If imagery does not have proper closure, it is possible that feelings triggered in imagery could spill over into patient’s lives outside the session in undesirable ways (Young, Klosko, & Weishaar, 2003).

Once the therapist has presented a safe place for imagery and patients feel comfortable, they move into childhood imagery. The purpose is to observe the patient’s affect and the themes that emerge. The themes and emotions assist in identifying Early Maladaptive Schemas and understanding their origins. This is generally elicited through imagery with the use of upsetting childhood images. This image is typically a parental figure, but can also be significant others, such as peers, extended family, teachers, siblings, and even strangers that contributed to the formation of the schema. The therapist, again as with previous imagery, begins with an unstructured image, by simply instructing the patient to picture an upsetting image from childhood. This allows the patient to convey what was most difficult about childhood. Then, the therapist moves into more structured images, in an attempt to cover all significant others who contributed to the patient’s schemas (Young, Klosko, & Weishaar, 2003).

After exploring the origins of Early Maladaptive Schemas, through upsetting childhood imagery, the therapist and the patient switch imagery to a current or adult situation that feels the same. This is an important link for the patient, as it forges a direct link between childhood memories and the patient’s adult life. If a patient has relationship or marital problems, imagery can be used to link their past to the present by presenting unmet core emotional needs and/or
themes between how he/she currently feels with their spouse and how they felt with his/her childhood parental figures (Young, Klosko, & Weishaar, 2003).

It is important that the therapist assists the patient to conceptualize, in schema terms, what happened in the imagery. This helps the patient develop a greater insight into the meaning of the imagery. The role of the therapist is to help the patient conceptualize the imagery session and assist the patient with connecting their Early Maladaptive Schemas to their presenting problems in their current lives (Young, Klosko, & Weishaar, 2003).

**Imagery Dialogues**

Imagery dialogues are one of the primary experiential change techniques used in Schema Therapy. Therapists encourage patients to have imagery dialogues with people who helped create their schemas in childhood and with those who currently reinforce their schemas. Most often parents are the most significant childhood figures. Therefore, parental figures are often the first characters addressed using imagery dialogues. Patients are asked to close their eyes and picture themselves with a parent in an upsetting situation. The images are often similar or the same to those that arose in the imagery for assessment. Therapists then encourage patients to express strong affect towards this parent, particularly anger. Therapists help patients identify the unmet needs by the parent, and then help patients get angry with the parent for not meeting those needs. The rationale for patients to express anger towards a parent is not simply to vent. While venting does have some merit, the main goal is to empower patients to fight against the schema and to distance patients from the schema. It is empowering for patients to express anger and stand up against the offending parent. Anger is thought of as emotional strength to stand up against the schema. What is attempted to be instilled is the feeling of entitlement to basic human rights. The therapist educates patients about what is believed as universal needs and basic rights
of children. “Expressing anger at the parent in sessions is of foremost importance in this stage of experiential work” (Young, Klosko, & Weishaar, 2003, p.124). It is not uncommon for patients to feel uncomfortable getting angry at their parents. Schema Therapy insists that “If patients have not gotten angry at the parent in a meaningful way, either in therapy or in their actual lives--then they have not gone through this stage” (Young, Klosko, & Weishaar, 2003, p.124). Later in treatment, the therapist and patient will discuss whether the patient can forgive the parent or not (Young, Klosko, & Weishaar, 2003).

There are times when patients feel too guilty to perform this exercise. They may have a belief that it is wrong to get angry at a parent. It is important to remind the patient that we are not condemning the parents as bad people by getting angry during imagery. Instead, we are getting angry at particular errors in their parenting (Young, Klosko, & Weishaar, 2003).

Imagery Work for Reparenting:

With Imagery work, reparenting is especially helpful for patients who concentrated schemas in the Disconnection and Rejection domain. Patients within the Disconnection and Rejection domain, as children, had their ability to relate to others, feel safe, love, nurtured, or worthy, virtually destroyed. Limited parenting is an approach in imagery work that allows the patient to go back into childhood mode and to learn to get from the therapist, and later from themselves, some of what they missed during childhood (Young, Klosko, & Weishaar, 2003).

Reparenting is a three step process. The first step consists of the therapist asking permission to enter the image and speak directly to the vulnerable child. The therapist accesses the patient’s Vulnerable Child mode by having them close their eyes and picturing an image of their little child mode, either now or in some past situation. Then the therapist has a dialog with the patient’s Vulnerable Child, using the patient as a liaison (Young, Klosko, & Weishaar, 2003).
Once the therapist has permission to speak directly to the patient’s Vulnerable Child, the second step consists with the therapist reparenting the vulnerable child. As the Healthy Adult in the image, the therapist provides the antidote to the patient’s core needs. Whatever the patient wants and is appropriate is provided by the therapist. The therapist will ask questions such as, “What do you want from me?” “What can I do to help you?” If a patient says, “I just want you to play a game with me,” the therapist would reply, “What game would you like to play?” (Young, Klosko, & Weishaar, 2003, p.132)

After the Vulnerable Child has been reparented, the last step consists of the therapist asking patients to access a nurturing part of themselves, which is modeled after the therapist. This often takes a few sessions, but the patient’s healthy side has to be stronger. The goal is for the patient’s Healthy Adult to meet the emotional needs of the Vulnerable Child in the imagery. Doing this exercise aims to build up a part of themselves that can satisfy their unmet emotional needs, and thus fight their schemas. When patients say they do not know what they are feeling, they are often out of touch with their Vulnerable Child. When performing imagery of their Vulnerable Child, they often are suddenly able to recognize what the feeling is. This link can be used as a strategy during future sessions for tapping into what the patient’s core feelings are, even when the adult side of the patient does not seem to know (Young, Klosko, & Weishaar, 2003).

Writing letters to parents or significant others that hurt them as a child is another experiential technique that can be done as an assignment and brought into therapy to discuss. Writing letters to parents is a way to summarize what the patient has learned about the parent as a result of doing the cognitive and experiential work. Patients can use letters as opportunities to state their feelings and assert their rights. The therapist can also suggest critical areas of interest,
such as what a parent did or did not do for the patient that was viewed as damaging in the patient’s childhood. In most cases, the therapist does not recommend the patient give the letters to parental figures. Occasionally, patients do decide to send the letters, but only after a great deal of time has been spent discussing the potential repercussions (Young, Klosko, & Weishaar, 2003).

The use of imagery for pattern-breaking is another experiential technique. The use of imagery to break avoidant and overcompensation coping styles can be highly effective. Patients simply imagine different ways of behaving in situations, rather than retreating into their typical coping styles. For example, someone who is typically avoidant in social situations practices being very talkative and social with the therapist through the use of imagery. Imagery helps patients, particularly avoidant and overcompensation coping styles, face their schemas and fight against them directly (Young, Klosko, & Weishaar, 2003).

**Behavioral Pattern-Breaking**

The behavioral pattern-breaking stage is usually the final stage and is the longest and arguably the most crucial stage in schema therapy. Without this stage, relapse is likely. The behavioral pattern-breaking stage of treatment consists of patients attempting to replace their schema-driven patterns with healthier coping styles. “Even if patients have insight into their Early Maladaptive Schemas, and even if they have done the cognitive and experiential work, their schemas will reassert themselves if patients do not change their behavioral patterns” (Young, Klosko, & Weishaar, 2003, p.146).

The other parts of treatment prepare the patient for the task of behavioral change. The patient has gained psychological distance from their schemas. Cognitive and experiential stages help strengthen the healthy side of the patient, especially the ability to fight back against the
schema. These stages help prepare the patient to overcome blocks that may occur during the behavioral pattern-breaking change stage (Young, Klosko, & Weishaar, 2003).

Behavioral pattern-breaking refers not only to how one behaves in specific situations, but also to the types of situations one generally selects: whom one marries, the career one chooses, and friend selection. Behavioral pattern-breaking involves major life changes, as well as everyday behaviors. Patients can often create change in situation-specific behaviors with standard cognitive behavioral methods, but lifelong behavioral patterns driven by Early Maladaptive Schemas require an integrative approach. For example, assertiveness training may help a patient set limits with a partner, but assertiveness training alone will probably not change a broader life pattern with significant others. It is much easier for patients to change their cognitions and emotions than it is to break lifelong patterns of behavior. Therefore, the therapist must express empathy for how hard it is to change deeply instilled patterns of behavior, yet still confronting the necessity for change (Young, Klosko, & Weishaar, 2003).

It can be difficult to determine when it is appropriate for patients to enter the behavioral pattern-breaking stage. However, when patients are able to label their Early Maladaptive Schemas when they are triggered, understands the origins of their childhood schemas, and participates in schema dialogues in which they consistently defeat their schemas utilizing their healthy sides, they are probably ready to begin behavioral pattern-breaking (Young, Klosko, & Weishaar, 2003).

The first step is for the therapist and the patient to develop an extensive list of specific behaviors to change. The therapist and patient may refer to information they developed during the case conceptualization in the Assessment Phase, which detailed problematic behaviors,
imagery of problematic situations, the therapy relationship, relationships with significant others, and schema questionnaires (Young, Klosko, & Weishaar, 2003).

The therapist and patient may start by refining the case conceptualization they developed in the Assessment Phase, and elaborate on the process of schema surrender, avoidance, and overcompensation. They can begin to develop a list of specific behaviors of life circumstances that require change. It is salient that each major life area is covered separately, such as intimate relationships, work, and social activities, because the patient may have different schemas and coping styles linked to different life areas (Young, Klosko, & Weishaar, 2003).

Another important step in pattern breaking is creating detailed descriptions of problematic situations in the patient’s life. When the patient reports a situation that is a consistent schema trigger, the therapist helps the patient clarify specific behaviors by asking questions. The goal is to get each detail, blow by blow, to account for what happened. Together, they dissect what schemas were triggered, and how to change future behavior in similar situations (Young, Klosko, & Weishaar, 2003).

While it is not always possible, the therapist may be able to obtain information regarding the patient’s behaviors from significant others and/or friends. Gathering other person’s viewpoints can shed significant light on the patient’s maladaptive behavioral patterns. Consultations with partners, family members, and friends can supply additional perspectives. If the therapist is unable to meet with significant others, the patient can ask others for feedback and then discuss their responses in therapy. Imagery can be used to trigger events, particularly if the patient is having difficulties remembering the details of a problematic situation. The therapist can use imagery to replay the situation. The patient is accustomed to imagery, and patients can
often address thoughts, feelings, and behaviors that were previously inaccessible (Young, Klosko, & Weishaar, 2003).

Once the therapist and patient have made a list of problematic behaviors and life patterns, they discuss which is most important and which should be targets of change. This is accomplished by matching the most significant problematic behaviors which the desired healthy replacement behavior. It is important that the most problematic behaviors are the starting point. In many theoretical orientations, the easiest behavior is addressed first. Schema therapy believes in addressing the behavior that interferes with the patient’s life the most. It begins with core schemas and coping styles, with the goal being to help patient’s feel better as quickly as possible (Young, Klosko, & Weishaar, 2003).

Overcoming blocks is a major obstacle in the behavioral pattern-breaking stage. Early Maladaptive Schemas are deeply rooted and drive entire life patterns. Even when patients are dedicated to making life alterations, many difficulties may lie ahead when initiating new behaviors. Revisiting and retaking schema inventories may also shed light on how patients are coping with their maladaptive schemas and coping styles they are choosing to utilize.

Homework is a vital piece of pattern breaking. The patient and therapist discuss how their schemas played out in different scenarios. However, when patients fail to follow through with an assignment, the therapist should be trying to understand why the assignment is not done. The patient may already have the answer, if not, the therapist and the patient will need to understand what the block is. Maybe the assignment was too hard? Is the patient struggling with the discomfort of changing (Young, Klosko, & Weishaar, 2003)?

Imagery is another tool used to investigate a potential block. The therapist asks the patient to visualize the problematic situation and to describe what happens when he/she attempts
the new behavior. Together, they explore the point at which the patient becomes stuck. What feelings and thoughts happen during this moment? Who are the characters? What are they thinking? In this format, they can often discern the nature of the block (Young, Klosko, & Weishaar, 2003).

The therapist can have the patient have dialogues between the blocked side of the person and the side that is attempting the new behavior. The patient can conduct the dialogue in imagery or role play the two sides by switching chairs. The therapist coaches the healthy side only when necessary. The therapist works to identify what is blocking the change (Young, Klosko, & Weishaar, 2003).

The therapist and patient can write a flash card addressing the block. In the flash card, they fight the relevant schemas and maladaptive coping styles. The flash card summarizes the advantages and disadvantages of continuing the maladaptive coping style, spells out the healthy behavior, and provides solutions to practical problems (Young, Klosko, & Weishaar, 2003).

Once the therapist and patient have identified the block and attempted to work through it, then the patient tries the new behavior again as a homework assignment. The level of difficulty may be adjusted into gradual steps, or breaking the assignment up into smaller sections. If the patient is unable to complete the assignment, it is possible to shift the focus to another behavioral pattern and come back to it later. Nonetheless, it is important that the therapist not become sidetracked in the pursuit of behavioral change. However the situation plays out, the therapist should continue to use empathic confrontation to push for behavioral change (Young, Klosko, & Weishaar, 2003).

If none of the above works, the therapist, as a last result could consider setting contingencies that reward the behavior. Patients could reward themselves for carrying out the
new behavior as part of the homework assignment. The reward will vary depending on what is desirable to the patient. The ultimate contingency is for the therapist to suggest a break from therapy, possibly time-limited. The therapist and the patient decide how much longer they want to attempt a behavioral change, and if no change is forthcoming during that period, they agree to cease therapy temporarily. The therapist presents this as a readiness issue, possibly a current life circumstance, and the patient is welcome to resume therapy when the patient is ready. This is only for extreme cases, and should be approached and handled delicately (Young, Klosko, & Weishaar, 2003).

The therapeutic relationship can also be a tool in the behavioral pattern-breaking stage. Adlerian Psychology and Schema Therapy have a similar approach to the therapeutic relationship. Both have a shared stance to therapy, which is characterized by two people working equally toward a specific and agreed-upon goal. The patient’s behavior in therapy is another source of information.

**The Therapeutic Relationship**

Therapy is the collaboration of both art and science. While evidence-based practice has taken the front stage of literature attention, over forty years of research has consistently shown that the single most salient therapeutic component to positive change in therapy remains the therapeutic relationship (Sexton & Whiston, 1994). In fact, approximately 30% of positive client improvement is attributed to the therapeutic alliance (Asay & Lambert, 1999; Lambert & Barley, 2001; Norcross, 2002). Lambert and Barley (2001) suggested that the therapeutic relationship more consistently correlates to successful client outcomes compared to specific therapeutic techniques.
Adlerian Psychology and Schema Therapy have a strikingly similar approach to the therapeutic relationship. Although the terminology is different, both orientations identify the therapeutic relationship as a vital component of patient movement and change. While Schema therapy emphasizes the therapist and patient, collaboratively fighting against maladaptive schemas (Young, Klosko, & Weishaar, 2003), both orientations take a strong shared stance, which is characterized by two people working equally toward a specific, agreed-upon goal (Dinkmeyer & Sperry, 2000; Young, Klosko, & Weishaar, 2003). Although it is clear that Carl Rogers’s approach to the therapeutic relationship was influenced by Adler (Watts, 1995, 1998), both Schema and Adlerian Therapy maintain the therapist-offered core conditions of empathy, unconditional positive regard, congruency, and empathy that Rogers (1951) identifies.

As in many forms of therapy, both Schema and Adlerian therapy believe that therapy begins with establishing rapport with the patient and developing shared agreed upon goals. Both therapies are personal, empathic, warm, and genuine, while also taking a similar stance on not appearing as though they are perfect, nor as they have knowledge they are withholding from the patient. They both essentially let the therapist’s personality come through, and share appropriate emotional responses that might be helpful to the patient. They both use self-disclose when it might help the patient. The common goal both orientations adhere to is to create an environment that is accepting and safe, in which the patient can form an emotional bond with the therapist (Carlson, Watts, & Maniacci, Adlerian Therapy: Theory and Practice, 2006; Corey, 2009; Young, Klosko, & Weishaar, 2003).

A key characteristic of the therapeutic relationship both Schema and Adlerian Therapy uniquely adhere to is the therapeutic stance of empathic confrontation. Both Adlerian and Schema therapists empathically challenge patients when presented with distorted thinking or
problematic life patterns. Here again, the difference is Adlerian therapists challenge and confront convicational thinking, perceptions, and behavioral discrepancies (Dinkmeyer & Sperry, 2000), whereas Schema therapists challenge the patient to fight against early maladaptive schemas.

For Adlerians, encouragement is both an attitude and a way of interacting with patients in therapy (Carlson, Watts, & Maniaci, 2006). Empathic confrontation is the therapeutic stance of Schema therapy. The therapist uses this particularly in the Change Phase to promote the patient’s psychological growth. The therapist strives for the optimal balance between empathy and confrontation that will promote change. Empathic confrontation is not a technique; it is an approach to the patient that involves a true emotional bond. The therapist must genuinely care about the patient for the approach to work (Young, Klosko, & Weishaar, 2003).

Another unique attribute of Schema therapy regarding the therapeutic relationship is the use of limited reparenting. Limited parenting involves providing, with appropriate boundaries, what patients needed, but did not receive from their parents as children. The therapist helps decipher what child core emotional needs were unmet during the Assessment Phase. Then the therapist attempts to reparent, provide unmet needs, during the Change Phase. It is important to have a strong therapeutic alliance to reparent, as reparenting needs to feel safe and genuinely harmonious (Young, Klosko, & Weishaar, 2003).

Another unique trait of Schema Therapy is schema therapists pay close attention to their own schemas. It is encouraged in training and supervision that new therapists become aware of their personal schemas which are triggered in everyday life experiences, as these experiences can be helpful in therapy (Haarhoff, 2006). The therapist’s reactions to the patient can be a valuable resource in assessing patient’s schemas. Additionally, it is equally important for therapists to
become aware of their own schemas in regard to the individual patient. The therapist’s knowledge of one’s own schemas and coping styles can help therapists avoid mistakes. Conversely, if the therapist ignores or fails to recognize his or her emotional reactions, negative consequences can occur (Leahy, 2001). Therefore, it is important for schema therapists to become aware, early on, which of their own schemas are triggered by an individual patient (Young, Klosko, & Weishaar, 2003).

Here are several scenarios Schema Therapy (Young, Klosko, & Weishaar, 2003 p.187-196) describes in which the therapist’s schemas have a negative impact on the therapeutic relationship:

1. *The patient’s schema clashes with the therapist’s schemas.* One risk is that the patient’s schemas might clash with the therapist’s schemas in such a way that they trigger each other in a self-perpetuating loop.

2. *A mismatch exists between the patient’s needs and the therapist’s schemas or coping styles.* The patient might have needs that the therapist is not able to meet. Because of the therapist’s own schemas or coping styles, the therapist cannot give the patient the right kind of reparenting. Often the therapist resembles the parent who originally engendered the schema in the patient.

3. *Over-identification takes place when the patient’s and therapist’s schemas overlap.* If the patient and therapist have the same schema, the therapist might over identify with the patient and lose objectivity. The therapist colludes with the patient in reinforcing the schema.

4. *The patient’s emotions trigger the therapist’s avoidance behavior.* Sometimes the intensity of the patient’s emotions overwhelms the therapist and prompts him or her to
become avoidant. The therapist withdraws psychologically, or changes the subject, or otherwise communicates to the patient that it is not acceptable to have intense emotions.

5. *The patient triggers the therapist’s schemas, and the therapist overcompensates.* When the patient’s emotions alarm the therapist, some therapists overcompensate. Other therapists, however, who tend to overcompensate, may retaliate. They become angry with the patient; they attack and blame the patient.


7. *The patient satisfies the therapist’s schema-driven needs.* Therapists who do not monitor their own schemas are at risk to inadvertently exploit patients. Rather than focusing on the patient’s welfare, these therapists unintentionally use patients to fill their own unmet emotional needs.

8. *The therapist’s schemas are triggered when the patient fails to make “sufficient progress.”* Often therapists with Defectiveness, Failure, or Dependence/Incompetence schemas respond improperly to patients who do not improve in therapy. Such therapists express anger or impatience toward the patient, often perpetuating the patient’s schemas.

9. *The therapist’s schemas are triggered when the patient has a crisis, such as feelings of suicide.* Crisis has a high likelihood of triggering the therapist’s schemas. They test the therapist’s ability to cope in positive ways.

10. *The therapist envies the patient on an ongoing basis.* If the therapist is narcissistic, the therapist might envy the patient. In such cases, the patient has access to a source of
gratification that the therapist has longed for but never had, such as beauty, wealth, or success.

Since Schema Therapy is a relatively new therapy, and unfortunately there has not been a sufficient amount of research produced to discuss and assess its effectiveness. Additionally, there is particularly minimal literature from authors outside its main founders.

Nonetheless, Schema Therapy offers complimentary structure to a flexible orientation often accused of being too simplistic and loose. It is evident that many of Adler’s basic foundational principles have found their way into Schema Therapy, as with other many of psychological schools of thought, making the integration of Schema Therapy and Adlerian Psychology a nearly flawless coexistence.
References


INTEGRATING SCHEMA THERAPY WITH ADLERIAN PSYCHOLOGY

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