COMPASSION FOCUSED THERAPY

FOR ADCP

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What is Compassion?

- **Compassion:**
- **According to Martin Lowenthal, Compassion is a foundation for sharing our aliveness and building a more human world.**
- **Compassion gets a lot of attention in positive psychology.**
- **Compassion is considered as an essential quality shared by many people, and now it has its own therapy: Compassion Focused Therapy.**


Compassion

Compassion-focused therapy (CFT)

- (CFT) aims to help **promote mental and emotional healing** by encouraging people in treatment to be **compassionate toward themselves and other people**. Compassion, both toward the self and toward others, is an emotional response believed by many to be an essential aspect of well-being.

- Some main components of the approach are aspects of:

Cognitive behavioral therapy
Developmental psychology
Evolutionary psychology
Social psychology
Neuroscience
Buddhist philosophy.

ISSUES TREATED WITH CFT

can also be effective helping **people manage distressing thoughts, behaviors, with feelings associated with self-attack.**

Anxiety

Shame

Depression

Disordered eating

Anger

Self-injury

Psychosis

Ten Compassion Focused Therapy Exercises :

- **1. Soothing Rhythm Breathing.**
- To practice the soothing rhythm breathing exercise, first make sure that you are sitting comfortably with both feet flat on the floor. Rest your hands on top of your legs and close your eyes or look down at the floor. Let yourself have a gentle facial expression, like a small smile. Begin to focus on your breathing.
- Turn your attention to your body, sensing the weight of your body resting on the chair and the floor underneath you.
- When you're ready, slowly open your eyes and bring yourself back to the present moment. A small stretch and a deep breath can help you ready yourself for the rest of your day.

2. Simple Body Scan and Relaxation

- This exercise builds on top of the soothing rhythm breathing you just read about.
- Next, **focus on how your legs** feel. Imagine that all the tension in your legs is flowing down through your legs, into the floor, and away. Let the tension go. Imagine your legs feeling grateful that the tension is leaving.
- Focus on the **tips of your fingers** next. Imagine the tension stored there and allow it to be released, through your hands, your wrists, your arms, elbows, and shoulders, and finally all the way through your body to the floor.
- Next, **move on to the tension in your head, neck, and forehead**. Allow them to relax with each breath, and visualize the tension running down through your shoulders, your stomach and your back, all the way down through your legs and into the floor.
- Finally, **focus on your whole body**. Each time you breathe, focus on the **word "Relax."** Imagine your body becoming a bit more relaxed with every breath. Practice this breath for a few minutes. Allow yourself to **be grateful for your body**, and for your body to be grateful for the **special attention and release it just received**.
- When you are ready, get up and go about your day feeling a bit more relax.

3. Creating a Safe Place

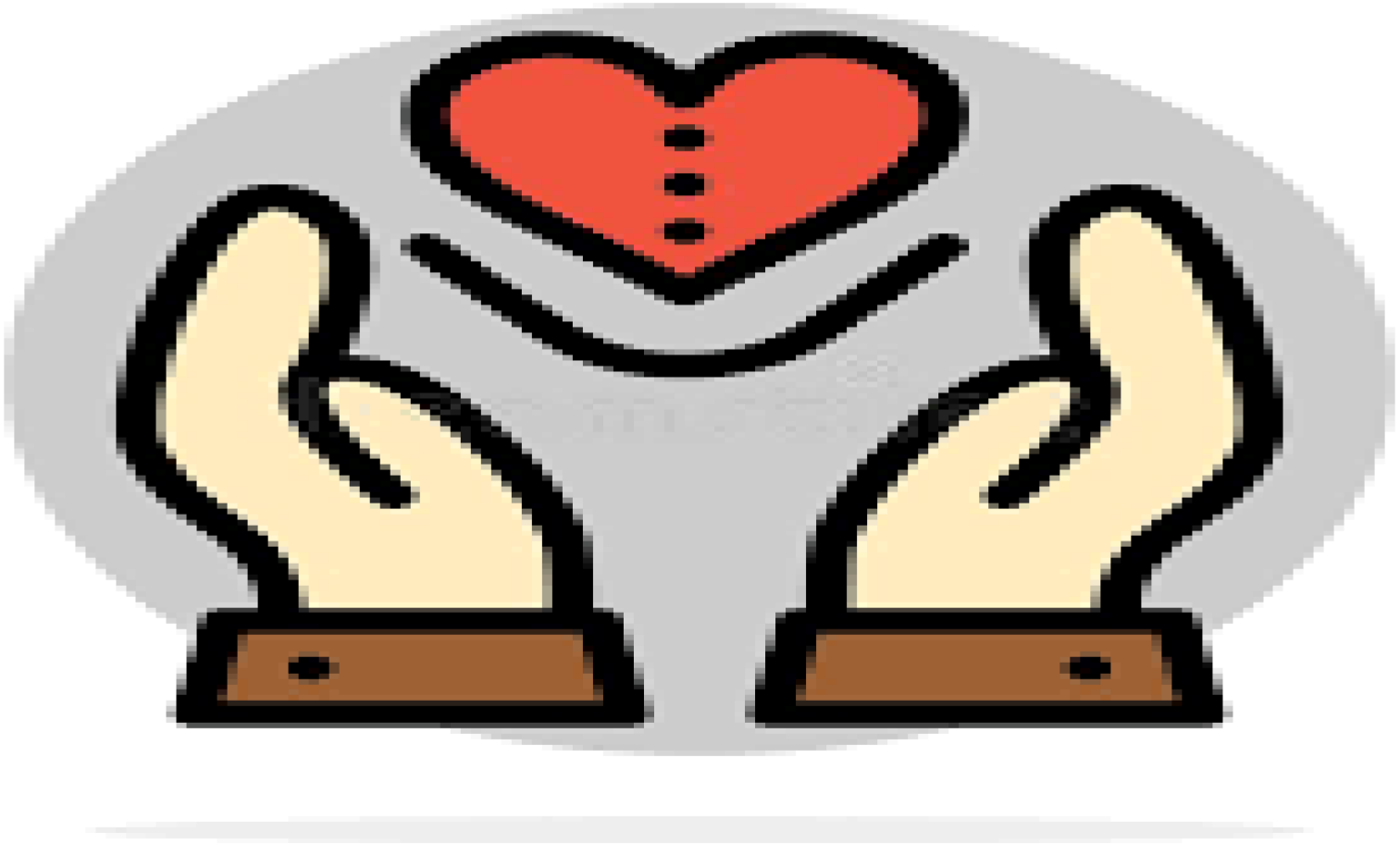
- Begin this exercise with soothing rhythm breathing. Create a sense of calmness, safety, and peace within yourself.
- Imagine looking around yourself. What can you see? **Your safe and peaceful place**
- Wherever this place is, focus on what you can feel In your safe place
- you may feel the **sun on your face**, a **breeze lifting your hair** or caressing your cheek or the heat of a campfire burning. You may **feel sand between your toes**

Continued safe place

- Next, think about what you can hear
- Now focus on what you can smell
- Allow your body to relax - your whole body, which includes your face. Let your face show your pleasure at being in the safe space.
- Finally, imagine that your safe place actually finds joy in your presence as well.

4. Compassionate Color

- **Imagine this compassionate color** surrounding you. Once it has surrounded you, imagine it entering through your chest, near your heart, and slowly spreading through every inch of your body.



focus on this color **as one of wisdom, strength, warmth, and total kindness**.
Create a facial expression to match the feelings of this color.
Allow yourself to **feel supported and loved.**

- **5. The Compassionate Self :**
- sense of self to develop, both for your compassion for others and for yourself.
- imagine that you are a deeply compassionate person. Think of all the qualities you would ideally have as that compassionate person.
- Focus on your desires to become a compassionate person and to be able to think, feel, and act compassionately.
- Imagine yourself with each of the qualities of compassion – wisdom, strength, warmth, and responsibility

- First, imagine yourself with **a wealth of wisdom**. This wisdom comes from your understanding about the nature of life, of our minds and bodies. Spend some time thinking about how much goes on inside of us which is not our fault.
- Next, imagine having a **compassionate strength.** Imagine yourself as a person that understands your own difficulties and those of others in a non-judgmental way, and the tolerance to withstand difficulties.
- Imagine, **warm and kind**, to yourself and to others. Imagine yourself speaking to someone kindly, and note the tone of your voice. Imagine reaching out to someone with warmth and feel what that might be like.

- Finally, imagine yourself with a **sense of responsibility**. Imagine that you have no interest in condemning or blaming others or yourself .
- only want to do the best you can to help yourself and others through a difficult situation.

6. Compassionate FlowingOut

- sit somewhere quiet where you won't be disturbed and begin to focus on your breathing. Think about a time when you felt very kind and caring towards a person or a beloved animal.

- Next, focus on the desire to help the person or animal, and the feelings of kindness that will guide you to help. Remember that in this exercise it is your intentions that are important, not how the person or animal responds.

- Bring to mind a specific time when you felt compassionate towards him or her. Imagine yourself expanding, as if you are becoming calmer, wise, stronger, and more responsible, and able to help him or her.

Pay attention to your body as you remember how it felt to be kind.

Spend some time expanding with warmth in your body.

Notice the genuine desire for this person to be free of suffering and to flourish.

Spend a minute or two thinking about the tone of your voice and the kinds of things you said, or the kinds of things you did or wanted to do to help.

Spend another minute or two on thinking about how good it felt to be kind to him or her.

Finally, focus only on your desire to be helpful and kind: **the sense of warmth, feelings of expansion, your kind tone of voice, the wisdom in your voice and your behavior.**

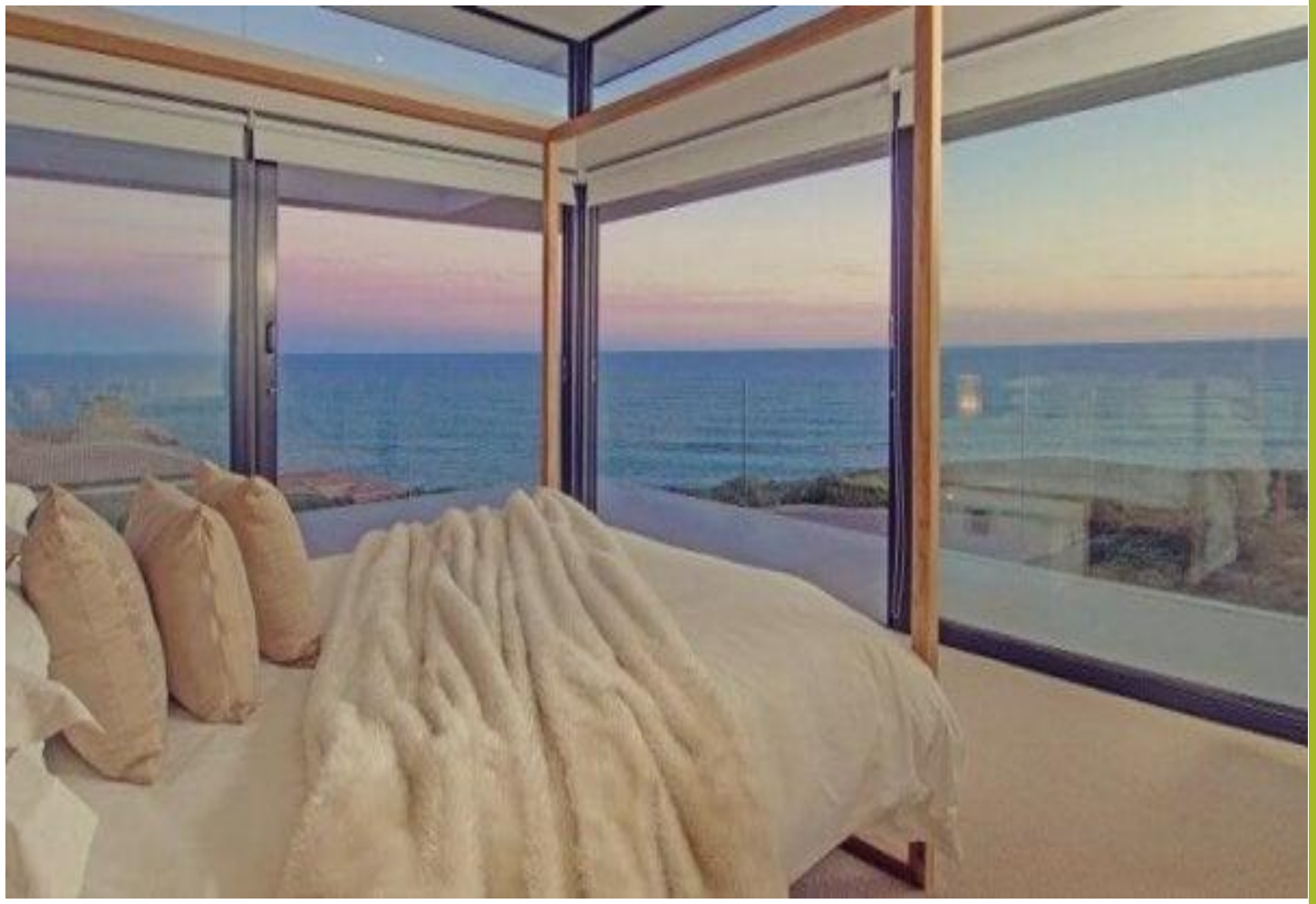
When you have finished this exercise, you may want to take some notes about how this felt foryou.

~~FOCUSING THE COMPASSIONATE SELF ON OTHERS~~

This exercise also requires a quiet place where you won't be disturbed.

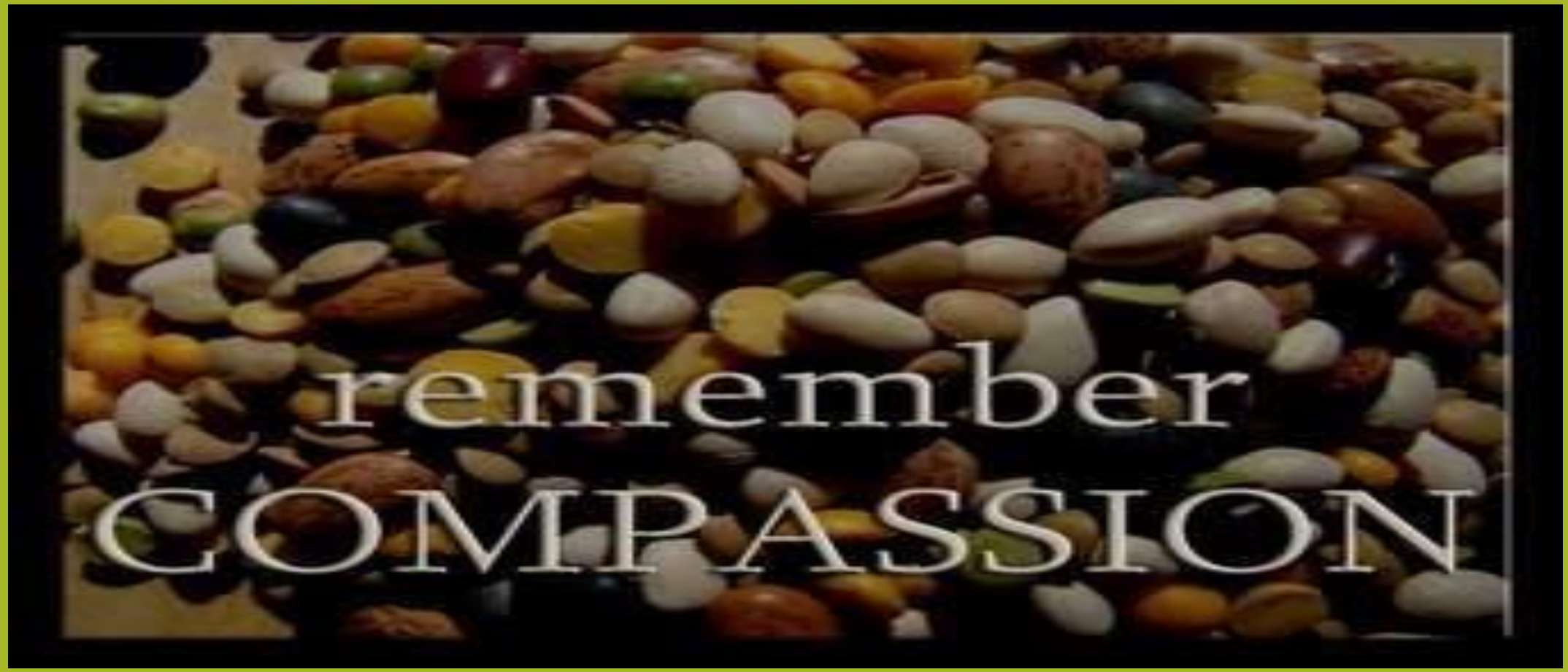
Try to create a sense of being a compassionate person, as you did in the previous two exercises.

Some days this will be easier than others, but hold on to even the slightest glimmer of feeling like a compassionate person.



- Next, think about someone you care about (e.g., a partner, friend, parent, child, or even a beloved animal). Focus on them and direct your attention towards them with three basic feelings and thoughts:
- **May you be well**
- **May you be happy**
- **May you be free of suffering**
- Remember that it is your behavior and intentions that are important, rather than how he or she will react. Be gentle, take your time, and allow yourself to focus on the desires and wishes you create in yourself for this other being.

Compassion Flowing Into Oneself: Using Memory


remember
COMPASSION

8. Compassion Flowing Into Oneself: Using Memory

- Memory can be a great tool for provoking and practicing compassion. Begin with your soothing rhythm breathing and practice this for a minute or two.
- Once you feel that your body has slowed down a bit, prepare for the exercise by allowing your body posture and facial expression to become compassionate.
- Feel free to play around with postures and facial expressions, but whatever expression and posture you go with, they should be gentle.

- Once you are ready, think of a time when someone was kind to you. Like the previous exercise, you shouldn't think of a time when someone was kind to you because you were in distress; the point of this exercise is not to focus on your distress, but on the desire to be kind and to help others.
- Put on your compassionate expression and adopt the compassionate body posture you have cultivated as you remember the compassion you received. Recall how it felt to receive that kindness.

- While recalling the memory, focus on the important sensory qualities of your memory.

Try the following steps:

1. Focus on the kinds of things this person said, as well as the tone of their voice when they spoke. Spend one minute on this.

2. Next, focus on the feeling of the emotion in the person - what they really felt for you at that moment. Focus on that for another minute, if you can and would like to.

3. Finally, focus on the entire experience. Think about whether they touched you in a friendly or comforting way, or whether they helped you in some other way. Allow the experience of gratitude and joy in being helped to grow in you. Remember to keep your expression as compassionate as you can. Spend a few minutes in this step.

FOCUSING THE COMPASSIONATE SELF ON YOURSELF

9. Focusing the Compassionate Self on Yourself

- This exercise can be focused on one of two different "selves." You can do both if you wish, but focus on only one at a time.
- First, you can focus your compassion on your troubled self. It will help if you have completed the exercise in which you imagined yourself as a completely compassionate person, full of wisdom, strength, warmth, and responsibility.
- Imagine that you are watching a video of yourself like you're watching a movie. You watch yourself get up in the morning, moving around your bedroom, and preparing yourself for the day. Be sure to keep your compassionate and kind position as you watch this "home movie."
- Notice how the person you are watching is troubled by self-critical thoughts or feelings, and be in touch with their struggle - but don't get dragged down into it. Keep your compassionate self forward, looking through the eyes of compassion and with the intention of being warm, kind, and helpful

- Next, imagine yourself in a situation where you become anxious. Remember to keep your compassionate position. Look at your anxious self through the eyes of your compassionate self and practice compassion for the person that you see. Understand and empathize with your anxious self, and extend compassion to him or her.
- Imagine how you might like to help that person, what you might want to say to help them deal with their anxiety. You might say something to validate their emotions, or you may say something encouraging to help them recognize their ability to pull through the anxiety. Whatever you say, make sure it's kind and helpful.

10. Creating a Compassionate Ideal

- This exercise will be helpful to complete the other exercises before moving on to this one, especially the initial exercise, the exercise in which you cultivate a compassionate expression, and the safe place exercise.
- Engage your soothing rhythm breath and adopt your compassionate expression. Recall your safe place, with all the sights, sounds, smells, and feelings that come with it. Remind yourself that this is your special place and that it delights in your presence. If you wish, this is a good place to create and "meet" your compassionate self.
- Create a compassionate vision of yourself. It may be created out of the mist in front of you, or it may snap into existence once you have the idea in mind. It may be walking toward you with a smile

Once you build a solid image of your compassionate self, think about the qualities that your compassionate image holds. These questions can help you build a good image:

- How would you like your ideal caring, compassionate image to look or appear?

Would you want your ideal compassionate image to feel/look/seem old or young; to be male or female (or non- human looking, e.g. an animal, sea or light)?

- How would you like your compassionate image to sound? What would be a compassionate voice tone for you?

- Are there any other sensory qualities that would come with your image, such as colors or sounds?

- How would you like your ideal compassionate image to relate to you? What would help you sense their commitment and kindness for you?

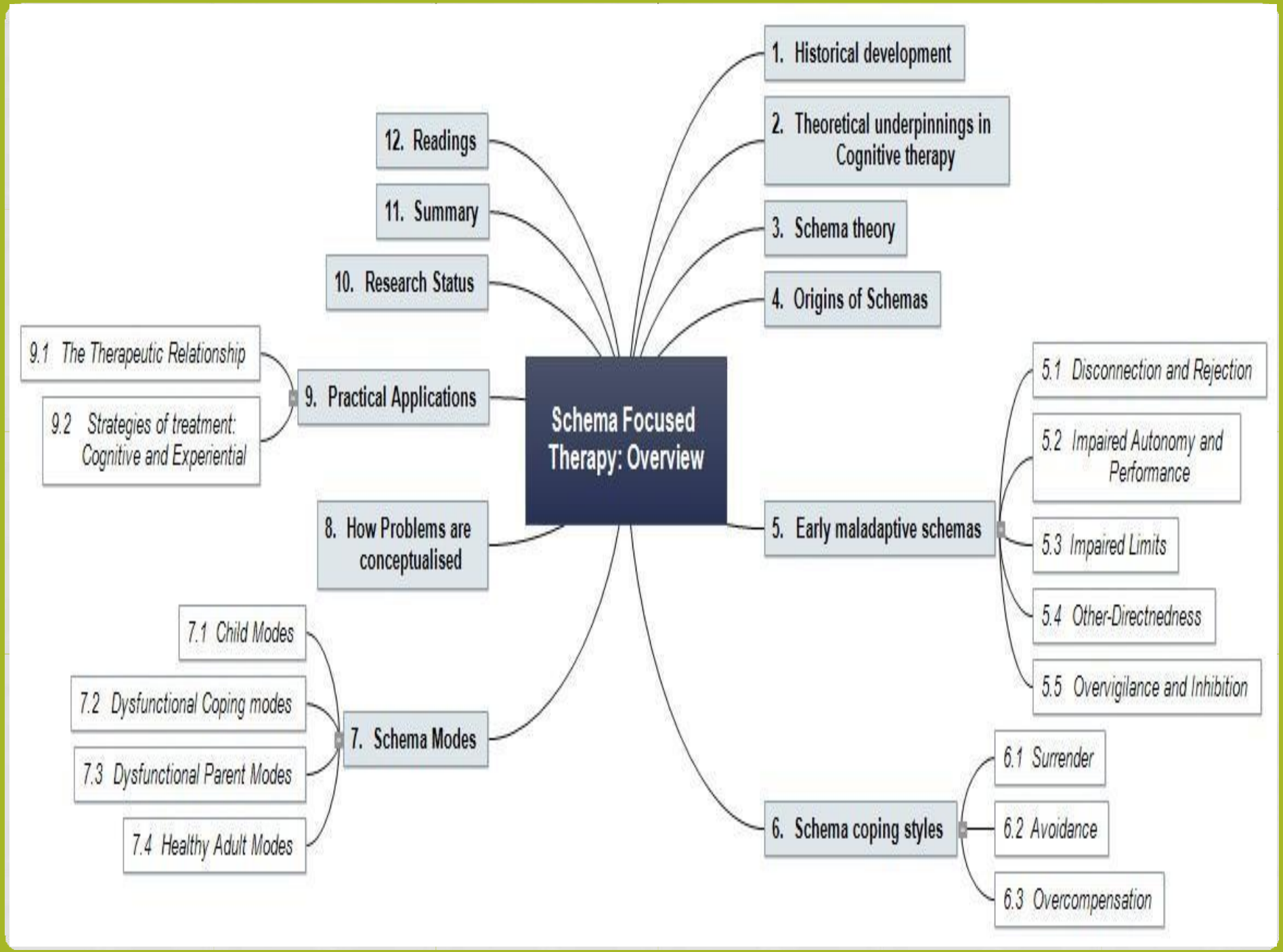
- How would you like to relate to your compassionate image?

- Remember that your compassionate image wants you to be free from suffering and to flourish. The compassionate self understands that we are all just doing the best we can, and it understands that the emotions that can pop up in our minds are not our fault.
- Experience what it is like to focus on the feeling that another being values and cares for you unconditionally. Focus on the idea that your compassionate self is looking at you with warmth and kindness, and imagine that they have the following desires foryou:
- That yoube well
- That yoube happy
- That you be free from suffering
- Practice this exercise as much as you need to tap into your compassionate self and surround both yourself and others with love, acceptance, and compassion.

LIMITATIONS OF COMPASSION FOCUSED THERAPY

- While CFT may be effective for those who are comfortable with the concept of being soothed or cared for, not all people share this disposition. Some individuals in treatment may be afraid of compassion, while others may feel they are not worthy of being treated compassionately. Some persons may even find it challenging to understand compassion itself.
- Issues may also arise when performing exercises involving mindfulness and compassionate imagery. Some people may find it difficult to enter a state of mindfulness, and failure may lead to self-criticism. Other people may be unable to focus on or even sense compassionate imagery. The use of images of known people or events may also bring to mind unwanted associations and negative past experiences. Treatment may be less effective with those who are experiencing intense anger or rage.

SCHEMA THERAPY OVERVIEW


Schema Focused Therapy: Overview
1. Historical development
2. Theoretical underpinnings in Cognitive therapy
3. Schema theory
4. Origins of Schemas
5. Early maladaptive schemas
5.1 Disconnection and Rejection
5.2 Impaired Autonomy and Performance
5.3 Impaired Limits
5.4 Other-Directnedness
5.5 Overvigilance and Inhibition
6. Schema coping styles
6.1 Surrender
6.2 Avoidance
6.3 Overcompensation
7. Schema Modes
7.1 Child Modes
7.2 Dysfunctional Coping modes
7.3 Dysfunctional Parent Modes
7.4 Healthy Adult Modes
8. How Problems are conceptualised
9. Practical Applications
9.1 The Therapeutic Relationship
9.2 Strategies of treatment: Cognitive and Experiential
10. Research Status
11. Summary
12. Readings

- Describe the Historical development and Theoretical underpinnings from Cognitive therapy
- Define the Origins of Schemas
- Describe in detail the Early maladaptive schemas
- Understand and describe types of Schema coping styles
- Give an overview of Schema Modes
- How Problems are conceptualised
- Practical Applications
- Read: Ohanian & Rashed: Chapter 8 Schema therapy in Dryden, W. (2012) Cognitive Behaviour Therapies, London Sage:

- Schema therapy, which was developed by Jeffrey Young (1990; Young et al., 2003), stems from cognitive behavioral therapy (CBT) and has been attracting increasing attention since it was firstproposed.
- Young created schema therapy predominantly for patients who did not respond well to —classical‖ CBT treatment.
- These patients often experience a variety of symptoms and typically display complex interpersonal patterns, which may
- be either fluctuating orpersistent;
- they usually meet the criteria for one or more personality disorders.

- Although as a whole CBT is quite effective for the mood and anxiety disorders, some patients continue to show symptoms or experience relapses subsequent to treatment, particularly in chronic cases (Durham, Chambers, MacDonald, Power, & Major, 2003; Fournier et al., 2009).
- For these patients, a different approach would seem to be required. (Young, 1990; Young, Klosko, & Weishaar, 2003).
- Young suggests that certain patients are a poor fit for cognitive therapy and require a more extensive treatment approach, in part because of their difficulty identifying, accessing, and changing their cognitions and emotions.
- Young's schema theory does not attempt to compete with Beck's theory, but rather expands on it for a treatment-resistant clients
- Places greater emphasis on the developmental origins of severe psychopathology.

- Compared to CBT, schema therapy has a more intensive focus on the following three issues:
- **1. Problematic emotions**, which are in the foreground, alongside the cognitive and behavioral aspects of the patient's problems
- **2 Childhood issues**, are of much greater importance than in standard CBT, enabling schema therapy to integrate approaches that have been mainly considered psychodynamic or psychoanalytic
- **3 The therapeutic relationship**, plays a very important role is conceptualized as —limited re-parenting,‖

- Schema therapy is based on Becks cognitive therapy model
- Adopts the systematic and empirical approach to assessment and treatment
- Shares the following fundamental concepts:
  - The collaborative nature of the therapeutic relationship in directive role of the therapist.
  - Psychoeducation.
  - Emphasis on the cognitive and behavioural change; goal setting and structured home-based tasks; and teaching of skills as necessary.
- It builds on Beck's (1967) early definition of schemas and modes in the revised model of cognitive therapy (1997)

- Young draws on other theories to find ways of conceptualising problems:
- **psychodynamic models** bring the issues of childhood origins, and conscious processes, transference and counter transference and the necessity to process trauma on an emotional level.
- **Object relations therapy** directs the focus of interpersonal relationships to families of origin in the shaping of the child's view of self and of the world.
- **Attachment theory** (Ainsworth & Bowlby 1991). Bowlby's concept of the dysfunctional "internal working models" is similar to early maladaptive schemas.
- **Experiential therapies** like Gestalt therapy bring the emotional change skills into play.
- Schema theory is tightly woven with cognitive, behavioural, emotional and experiential strategies to form a unifying conceptual framework based on a solid therapeutic relationship

- Schema theory has four main concepts:
- 1. Early maladaptive schemas (EMS).
- 2. Schema domains.
- 3. Coping styles.
- 4. Schema modes.

- Young theorised that EMS developed when children's core emotional needs of consistently not met.
- Five core emotional needs considered universal:
- 1. Secure attachment to others that leads to safety and stability.
- 2. Autonomy, competence and a sense of identity.
- 3. Freedom to express invalid needs and emotions.
- 4. Spontaneity and play.
- 5. Realistic limits and self-control

- 4 mechanisms develop early maladaptive schemas:
- **1. Toxic frustration of needs**: refers to an absence of healthy experience.
- **2. Traumatisation or victimisation:** consists of specific traumatic an abuse of experiences.
- **3. Too much of a good thing:** where parents do not set realistic limits, overprotective or overinvolved.
- **4. Selective internalisation or identification with significant other:** internalisation of aspects of parents thinking and behaviour

- The development of schemas is also influenced by the child's emotional temperament interacting with negative childhood experiences.
- Nature and nurture debate

- Early maladaptive schemas (EMS) **defined**as:
- 1. A broad, pervasive theme or pattern
- 2. Comprised of memories, emotions, cognitions and bodily sensations
- 3. Developed during childhood or adolescence
- 4. Elaborated throughout one's lifetime
- 5. Dysfunctional to a significant degree
- (Young et al 2003).

- EMS serve as templates for the processing of data experiences and have certain core characteristics:
- They have **unconditional rigid beliefs** and feelings about oneself, and the world that the individual never challenges.
- They form the **core of the individual's sense of self**.
- They are self perpetuating and resistant to change.
- They operate **outside** individual's conscious **awareness.**
- They are **triggered** by events relevant to the particular schema, and associated with extreme negative emotions.
- Behaviours in do not form part of the schema; instead the **schema drives the behaviour**.
- Schemas can be positive or negative, can develop early or late in life, vary in degrees of severity.

- 18 EMS Identified an d grouped under five domains reflecting the five areas of core emotional needs identified above.
- Five domains:
- 1. **Disconnection and rejection**: the lack of secure attachment.
- 2. **Impaired autonomy and performance**: the lack of competence or a sense of identity.
- 3. **Impaired limits**: the lack of freedom to express valid needs and emotions.
- 4. **Other –Directedness**: the loss of spontaneity a n d play.
- 5. **Over vigilance and inhibition**: the loss of realistic limits a n d self control.
- EMS vary in severity a nd progressiveness; c a n be unconditional formed in the early as part of life a nd conditional schemas which are set to develop later.
- Schema perpetuation refers to all thoughts, feelings a nd behaviours which reinforce a nd perpetuate the schema resulting in the maladaptive behaviour patterns seen.

Table 1.1 Early maladaptive schemas (Young et al., 2003) and schema domains

Schema domain	*Schemas*
Disconnection and rejection	Abandonment/instability
	Mistrust/abuse
	Emotional deprivation
	Defectiveness/shame
	Social isolation/alienation
Impaired autonomy and achievement	Dependency/incompetency
	Vulnerability to harm and illness
	Enmeshment/undeveloped self
	Failure
Impaired limits	Entitlement/grandiosity
	Lack of self-control/self-discipline
Other-directedness	Subjugation
	Self-sacrifice
	Approval-seeking
Hypervigilance and inhibition	Negativity/pessimism
	Emotional inhibition
	Unrelenting standards
	Punitiveness

- This schema domain is characterized by attachment difficulties. All schemas of this domain are in some way associated with a lack of safety and reliability in interpersonal relationships.
- The quality of the associated feelings and emotions differs depending on the schema—for example, the schema —abandonment/instability‖ is connected to a feeling of abandonment by significant others, due to previous abandonment in childhood.
- Individuals with the schema —social isolation/alienation,‖ on the other
- hand, lack a sense of belonging, as they have experienced exclusion from peer groups in the past.
- Patients with the schema —mistrust/abuse‖ mainly feel threatened by others, having been harmed by people during their childhood.

5.2. IMPAIRED AUTONOMY AND PERFORMANCE

- People with these schemas perceive themselves as dependent, feel insecure, and suffer from a lack of self-determination.
- They are afraid that autonomous decisions might damage important relationships and they expect to fail in demanding situations.
- People with the schema ―vulnerability to harm and illness‖ may even be afraid that challenging and changing their fate through autonomous decisions will lead to harm to themselves and others.
- These schemas can be acquired by social learning through models, for example from parent figures who constantly warned against danger or illnesses, or who suffered from an obsessive–compulsive disorder (OCD)
- he schema ―dependency/incompetency‖ may develop when parents are not confident that their child has age-appropriate skills to cope with normal developmental challenges.
- Schemas Can also develop when a child is confronted with demands which are too high, when they have to become autonomous too early and do not receive enough support to achieve it. Thus patients with childhood neglect, who felt extremely overstressed as children, may develop dependent behavior patterns in order to ensure that somebody will provide them the support they lacked earlier in life, and thus do not learn a healthy autonomy.

- People with impaired limits schemas have difficulty accepting normal
- limits.
- It is hard for them to remain calm and not cross the line,
- They often lack the self-discipline to manage their day-to-day lives, studies, or
- jobs appropriately.
- People with the schema “entitlement/grandiosity” mainly feel entitled and tend to self-aggrandize.
- The schema “lack of self-control/self-discipline” is principally associated with impaired discipline and delay of gratification.
- These schemas are learnt by direct modeling and social learning. Often patients were spoiled as children, or their parents were themselves spoiled in their childhoods and/or had problems accepting normal limits.
- These schemas can also develop when parents are too strict, when they inflict too much discipline, and when limits are too narrow. In such situations, these schemas develop as a kind of a rebellion against limits and discipline in general.

- People with other-directedness schemas typically put the needs, wishes, and desires of others before their own. Most of their efforts are directed towards meeting the needs of others.
- Individuals with a strong —subjugation‖ schema always try to adapt their behavior in a way which best accommodates the ideas and needs of others.
- In the schema —self-sacrifice,‖ the focus is more on an extreme feeling of responsibility for solving everyone else's problems; typically feel that it is their job to make everybody feel good.
- Schema —approval-seeking‖ have as a sole purpose pleasing others; thus all their actions and efforts reflect that desire, rather than their own wishes.
- With regard to the biographical background and development during childhood, these schemas are often secondary.
- The primary schemas are often those from the domain —disconnection and rejection‖. I.e., schemas in the domain —other-directedness‖ may have developed to cope with schemas of disconnection and rejection..

- People with Overvigilance and Inhibition schemas avoid the experience and expression of spontaneous emotions and needs.
- People with the schema —emotional inhibition‖ devalue inner experiences such as emotions, spontaneous fun, and childlike needs as stupid, unnecessary, or immature.
- The schema —negativity/pessimism‖ corresponds with a very negative view of the world; people with this schema are always preoccupied with the negative side of things.
- Schema —unrelenting standards‖ constantly feel high pressure to achieve; they do not feel satisfied even when they achieve a lot, as their standards are extremely high.
- The —punitiveness‖ schema incorporates moral codes and attitudes that are very punitive whenever a mistake is made, regardless of reason.
- These schemas are acquired by reinforcement and social modeling, for example when parent figures mocked the spontaneous expression of feelings, thus teaching their children to be ashamed of being emotional.
- This can also take place indirectly, for example when parents reinforce only achievement and success, and devalue or ignore other important aspects of life such as fun and spontaneity.
- Some patients with these schemas report mainly negative experiences regarding intense emotions in their childhood. They started to avoid intense emotional experiences in order to protect themselves against these aversive stimuli.

SUMMARY: SCHEMA DOMAINS AND BASIC

Table 1.2 The relationship between schema domains and basic needs

Schema domain	*Related basic needs*
Disconnection and rejection	Safe attachment, acceptance, care
Impaired autonomy and achievement	Autonomy, competence, sense of identity
Impaired limits	Realistic limits, self-control
Other-directedness	Free expression of needs and emotions
Hypervigilance and inhibition	Spontaneity, playfulness

- 3. Broad maladaptive schema coping styles of identified.
- 1. Surrender
- 2. Avoidance
- 3. Overcompensation

- With a surrendering coping style, a patient experiences schema-associated feelings very intensely and surrenders as it were to the —messages‖ of the schema, thus accepting them.
- In a surrendering coping mode, the client behaves as if the schema was true and there was no other choice but to tolerate b a d treatment by others.
- the subjugating patterns of clients with a subjugation schema frequently have had severe sexual childhood abuse experiences
- they tend to accept abuse in intimate relationships later in life as well
- Domestic violence repeats a pattern

- Avoidant schema coping: when people avoid activation of the schemas or the emotions associated with them in order to protect themselves.
- Behavior patterns that are typical are social withdrawal and avoidance or lack of emotional contact withothers.
- In the therapeutic relationship, this coping style is activated when the therapist feels a lack of connection and contact with the client.
- Other behavior patterns c a n regarded as emotional avoidance are substance abuse to avoid experience of and dealing with
  - Emotions; keeping themselves continuously occupied in order to maintain a constant level of stimulation, to avoid feelings. This might take the form of computer games, workaholism, television and the Internet, or overeating.
- When patients report the use of such activities to reduce feelings of anxiety and so on, we speak about an avoidant schema coping.

- With the Overcompensation schema people act as if the opposite of the schema was true.
- People with a failure scheme, might show off and talk excessively about their achievements.
- Mistrust/abuse schema might behave in an overly self-centered and aggressive manner. Sometimes people with a mistrust/abuse schema who are overcompensating even abuse others in order to avoid abuse or threat against themselves.
- Subjugation schema insist that others subjugate themselves to them and accept their ideas without discussion.
- In the therapy situation, overcompensation can be easily identified in the therapeutic relationship when the therapist feels dominated, driven into a corner, or even threatened by a patient.
- Patients with narcissistic overcompensation,typically devalue their therapist, provoking them by questioning their experience and qualifications, and so
- on.
- In contrast, people with an obsessive-controlling overcompensation
- mode might correct their therapist in a very detailed and rigid way. In both
- cases, the therapist feels controlled and devalued.

- A —schema mode‖ is defined as a current emotional state which is associated with a given schema.
- Schema modes can either change frequently or be very persistent.
- In patients with many different schemas and intense schema modes, it is often much easier to address these modes than to refer to the schemas behind them.
- Schema modes are divided into modes associated with mostly negative emotions and modes used to cope with these emotions.

- There are 4 Modes overall:
- 1. Child Mode
- 2. Dysfunctional Coping Modes
- 3. Dysfunctional Parent Modes
- 4. Healthy Adult Modes

- Child modes are associated with intense negative emotions such as rage, sadness, and abandonment.
- They resemble the concept of the —inner child,‖ which is used in many therapies
- A patient with a mistrust/abuse schema, for example, may feel threatened and at the mercy of others when they are in the abused child mode

- Dysfunctional coping modes are related to avoidant, surrendering, or overcompensating schema coping.
- In avoidant coping modes, people avoid emotions and other inner experiences, or avoid social contact altogether.
- In overcompensating coping modes, people stimulate or aggrandize themselves in order to experience the opposite of the actual schema- associated emotions.

- The other category of highly emotional modes is the dysfunctional parent modes.
- they are viewed as internalizationsof dysfunctional parental responses to the child.
- In dysfunctional parent modes, people keep putting pressure on themselves or hate themselves.
- Patients with a mistrust/abuse schema, de-value and hate themselves when they are in the punitive parent mode.

- Healthy modes are the modes of the healthy adult and
  the happy child.
- In the healthy adult mode, patients are able to view their life and their self in a realistic way.
- They are able to fulfill their obligations, but at the same
- time can care for their own needs and well-being.
- This mode has conceptual overlap with the psychodynamic concept of ―healthy ego functioning.‖
- The mode of the happy child is particularly related to fun, joy, and play.
- Don't we all want to be like this!

- Accurate identification of EMS; coping styles, and their links to negative childhood experiences is essential for constructing a case conceptualisation.
- Therapist begins by assessing the clients presenting problems clearly and in specific terms to enable both therapist and client to stay focused on them.
- A focused life history is taken to establish whether the clients current difficulties represent dysfunctional life patterns in the client relationships and work.
- The therapist pays particular attention to schema eruption in the past, schema triggers and coping styles used by the client.
- Various schema inventories can be used to assess the specific elements required: Young schema questionnaire (YSQ-L3)
- Young Parenting Inventory (YPI)
- Young - Rygh Avoidance Inventory
- Young Compensation Inventory

- A detailed and technical analysis linking current situations to past EMS is the difference to standard CBT

- Following assessment and education of the client the most important phase is referred to as "changed phase".
- The therapist employs cognitive, experiential and behavioural strategies to challenge and modify early maladaptive schemas, as well as coping styles and modes.
- While utilising specific techniques the schema therapist makes use of the therapeutic relationship as a platform for assessment and treatment.

- The therapeutic relationship is an important component of schema therapy.
- In the assessment phase therapist notes schema activation in the therapeutic relationship, becoming aware on how to establish rapport, conceptualise the client's difficulties and assess the clients reparenting needs.
- There's a lot more emphasis placed on the nature of the therapeutic relationship and the idea of limited reparenting.
- This will be discussed in more detail later lectures

- Schema therapy focuses on two broad areas: cognitive strategies and experiential strategies.
- Cognitive strategies is used to introduce doubt about the nature of schemas working collaboratively with the client to encourage a more "healthy voice" to question and counter the schemas. This is classical cognitive therapy.
- Experiential strategies are used in all phases of schema therapy. They are used to elicit emotions and assess EMS. In the treatment phase there are used to meet clients emotional needs and help heal their EMS.
- Young et al (2003) "experiential strategies help clients in their transition from knowing intellectually that schemas are false to believing it emotionally".
- The most common experiential strategies are imagery, chair work and letters to parents

- There is a wealth of research on Young's schema theory and the applications.
- Carine (1997) confirmed that emotion is integral to schemas
- the psychometric properties of young schema questionnaires to be subject to rigourous research and have good psychometric properties
- schema mode inventory ca n be used reliably in the assessment of modes in schema therapy(Lobbestael et al 2010)
- the mode model is well researched with good outcome studies on the model (Giesen-Bloo et al 2006)
- please research on Athens and the application of schema therapy to depression, anxiety and phobias.

- Young (1990) originally developed schema therapy to treat patients who had failed to respond adequately to traditional cognitive-behavioral treatment,
- Schema therapy is a broad, integrative model; it has considerable overlap with many other systems of psychotherapy, including psychodynamic models. However, most of these approaches are narrower than schema therapy, either in terms of the conceptual model or the range of treatment strategies. There are also significant differences in the therapy relationship, the general style and stance of the therapist, and the degree of therapist activity and directiveness.
- Early Maladaptive Schemas are broad, pervasive themes or patterns regarding oneself and one's relationships with others that are dysfunctional to a significant degree. They play a major role in how individuals think, feel, act, and relate to others.
- Early Maladaptive Schemas are the result of unmet core emotional needs.
- We have defined 18 Early Maladaptive Schemas in five domains.
- A great deal of empirical support exists for these schemas and some of the domains.
- We have developed four main categories of modes: Child modes, Dysfunctional Coping modes, Dysfunctional Parent modes, and the Healthy Adult mode.

- Ohanian & Rashed: Chapter 8 Schema therapy in Dryden, W. (2012) Cognitive Behaviour Therapies, London Sage
- **Rafaeli, et al (2010) Schema Therapy: chapter 1 & 2 & 3**
- Advanced reading: **Young, et al . (2003): chap 1**
- Hawke & Provencher 2011 Schema Theory and Schema Therapy in Mood and Anxiety Disorders A Review
- Riso et al (2006) The Long-Term Stability of Early Maladaptive Schemas.
- Thimm (2010) Relationships between early maladaptive schemas and psychosocial development

"Your inability to turn off your critical voice, combined with your fear of disappointing your overbearing, demanding father, is causing you to lose faith in your fastball."


Thank You