The Community for Psychologists in Independent Practice
WWW.DIVISION42.ORG

Independent Practitioner

Winter 2014 • Volume 34 Number 1
division42.org

Schemas in clinical practice: What they are and how we can change them

by David Edwards

Extracted from

Pages 10-13

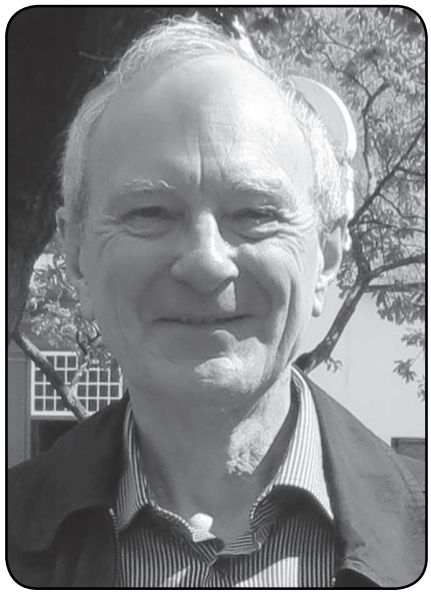
Bulletin of
Psychologists in Independent Practice

A Division of the American Psychological Association

Focus on Clinical Practice

Schemas in clinical practice: What they are and how we can change them

— David Edwards



Many current approaches to psychotherapy emphasize the importance of changing schemas. In this article I look at what schemas are and what we know about changing them. Addressing the schema level has always been part of Beck's cognitive therapy. This approach identifies three levels of cognition. Automatic thoughts, the strings of words that go through our minds as we go about daily activities, are closest to awareness. Underlying assumptions may not be explicit at first, but careful questioning and guided discovery often result in clients articulating the "if … then …" beliefs ("if I ask for what I want, I will be ridiculed" … "If I try to do this, I will fail") and implicit rules ("Don't get angry with your father," … "Don't let people see you're upset") found at this level. At the schema level, "core beliefs" are unconditional: "I am worthless" … "no one could love me, I'm unlovable" … "I am too helpless to get by without having someone strong around to show me what to do." The "downward arrow" technique uses a series of "What if…?" questions to help clients move from the level of automatic thoughts down to the level of underlying assumptions and on to the level of core beliefs. For example, "I'm late, I am going to get into trouble" ☞ "if I get into trouble, I will be scolded and ridiculed" ☞ "that means I am worthless and defective." Since schema level beliefs are often at the root of dysfunctional underlying assumptions, which in turn underlie problematic automatic thoughts, they may need to be addressed in order prevent relapse.

But why is the term "schema" used to refer to this deepest level? The concept has been central to psychology from the beginning. A century ago, Alfred Adler used the term "schema of apperception," for the underlying cognitive structures that organize personal meanings (Ansbacher & Ansbacher, 1958). This concept evolved from Kant (1724-1804) and Herbart (1776-1841). Kant used the term "schemas" and recognized the abstractive processes involved, which is why he called them "transcendental." Herbart, one of the first philosophers to contribute to psychology, used the term "apperceptive mass" for this organized, underlying meaning structure. These writers, in turn, influenced Vaihinger (1852-1933), who, in The philosophy of 'as if', published in 1911 (though written three decades earlier), argued that we experience the world not as it is but in terms of a representational model of it built up through experience. This model is abstractive, in that it distils generalizations and principles rather than presenting a fixed snapshot. It was Vaihinger's exposition that Adler drew on (Ellenberger, 1970). Schemas are not only abstractive, they are reconstructive. In perception, past experience shapes what we see and how we see it: a person with a history of abuse and maltreatment looks out at the world mistrustfully and may see a neutral face as threatening or interpret a neutral statement as hostile. This is called projection: the individual's internal working model is projected onto his/her everyday world. Identifying such "cognitive distortions" and testing and restructuring them is, of course, a basic intervention in cognitive therapy.

Today the term "internal working model" is associated with Bowlby's exposition of attachment theory. However, the concept of schema had been used in this sense in 1920 by the neurologist Henry Head who studied how individuals use an underlying mental model of their body located in space. This explains how individuals can (among other things) touch one part of their body with another with their eyes closed. "By means of perpetual alterations in position," observed Oldfield and Zangwill (1942, p.272), "we are always building up a postural model of ourselves which constantly changes. Every new posture or movement is recorded on this plastic schema."

This example shows how schemas are not only the basis of perception and our conceptual system, but also the basis of behaviors. Behavioral repertoires are also abstractive and reconstructive so that they can be applied to new situations, different from the ones

in which they were learned. Touching my nose with my finger is a specific performance of a generic behavior that is controlled and calibrated in the moment in terms of the schematic model of my body. Similarly, the wary and hostile behavior of the mistrustful person is tailored and adapted to the specifics of each new social situation.

By the late 19th century, two other features of the organization of schemas were well understood. First, representations of self, others and the world develop from birth (if not before). As Adler observed, "We must always reckon with the misinterpretations made in early childhood, for these dominate the subsequent course of our existence" (Ansbacher & Ansbacher, 1958, p.183). Today, the pervasive impact of early schemas in later life has been documented in the impressive body of research on attachment theory. The second aspect is that cognitive organization is not a single coherent system. There are interacting subsystems and some schematic organizations encode information in a manner that is at variance with information encoded in others. In the second half of the 19th Century, many clinical descriptions of dissociative phenomena were collected and studied and Janet's theory of *désagrégation*, and, in English, the concept of dissociation were used to explain the existence of this kind of disorganization or incompatibility. The concept of splitting - the development of two incompatible meaning systems relating to a single event, was used by Freud to account for a range of more subtle clinical phenomena (Ellenberger, 1970). The same insight would later appear in Kelly's (1955) cognitive theory as the fragmentation corollary: "a person may successively employ a variety of construction subsystems which are inferentially incompatible with each other."

Some of this incompatibility results from there being parallel systems of cognitive organization that encode information in different ways. Leventhal's (1979) perceptual motor theory of emotion separated out a conceptual system from a system of emotional schemas. This was taken up in Teasdale's (1993) Interacting Cognitive Subystems (ICS) model. This has a "propositional" system, where encoding is through language and the rules of logic and reason can be brought to bear. In the "implicational" system, the world is represented in a holistic way that can be accessed through imagery and metaphor. Language plays little or no role and if words are to impact on this system, their impact will be through metaphorical or poetic expression not logical statements. The ICS model, based on fundamental cognitive and brain research includes a very important feature: emotional systems in the brain are not directly connected to the propositional system. So work with language, logic, reason and insight has limited impact on the systems that drive emotional states. By contrast, the implicational system is directly connected to emotional systems with the result that changes in the implicational system can have a direct impact on emotions. The often observed disjunction between "head" and "heart," "reason" and "passion," or "thought" and "feeling" reflects this structural reality.

The term "cognitive" is often mistakenly used to refer exclusively to language based meanings (i.e., those in the propositional system). This is unfortunate since any system that makes meaning of experience and behavior is cognitive; this is why a great deal of fundamental cognitive research has been performed on animals, birds and even invertebrates. The meanings in the implicational system are no less cognitive than those in the propositional system. Emotions themselves are replete with meaning. They may have organized systems of expression in the limbic system, but these are mobilized in response to the meaning of events: danger, disappointment, loss, blame, social exclusion etc.

This means that the so called schema level where, for cognitive therapists, the core beliefs are encoded is far more than a set of propositions. In fact, it is not primarily encoded as propositions at all. Twenty five years ago Safran and Greenberg (1984) used Leventhal's theory to argue that in psychotherapy change in these schemas required activating them and working with them affectively. This evolved into Greenberg's (2004) emotion-focused therapy (EFT) in which emotional focusing techniques play a central role. Around this time, Blatt was discussing "cognitive-affective schemas," integrating concepts from object relations with attachment theory, and pointing out how this was leading to a convergence of the theories on which psychodynamic and cognitive-behavioral therapies were based (Blatt & Levy, 2003). In this period, too, Young (1990) used the term "early maladaptive schemas" to refer to these fundamental patterns that are often the source of psychopathology. Of course, early schemas based in the attachment system can be adaptive and unproblematic. It is when they are maladaptive that they become the focus of clinical attention. Like Greenberg, Young realized that, in order to change maladaptive schemas, it was essential to activate them and work to change them. His schema therapy was developed as a systematic approach to effecting this by promoting corrective experiences (Young, Klosko & Weishaar, 2003).

We might expect that early maladaptive schemas would automatically change in response to new experiences. The schemas of individuals raised in abusive homes should be updated and correct themselves automatically if the individuals get into a more stable social environment or into relationships with more secure and balanced people. While there is evidence that this can happen, it often does not. This is partly due to the self-fulfilling nature of schema driven behavior.

The wariness and suspicion of mistrustful individuals may alienate others and elicit the very hostility they are expecting. But It is also due to what Sullivan (1953) aptly termed "security operations," self-protective coping mechanisms that block the underlying schemas which, when activated bring with them intense emotional distress. Recognition that coping takes the form of various kinds of avoidance and compensation is also found in Adler's early work. Therapists will not make headway changing schemas in clients who are emotionally cut off (avoidant coping) or focusing on putting across to the therapist how important they are (a self-aggrandizing compensation). An important focus in schema therapy is to identify coping mechanisms and to weaken them to allow access to the underlying childhood schemas.

Therapies directed at modifying early schema patterns offer a number of approaches to bringing about schema change. One is through the relationship with the therapist. Individuals who have never felt safe, valued or cared for because of experiences with primary caretakers that were neglectful, inconsistent or abusive, will have relational schemas that embody attachment patterns that are insecure or disorganized. By providing an interpersonal experience that is consistent, authoritative, trustworthy and caring, therapists can actively impact these schemas by providing a corrective experience. In schema therapy, this is explicitly referred to as "limited reparenting." As schemas are activated, the painful memories associated with them are recovered and the therapist relates to the child in the memory just as s/he would to his/her own child or to a distressed child brought for therapy. However, this can only happen if the schemas are activated. So relational work requires that therapists engage emotionally with clients, and break through avoidances and compensations that prevent that engagement.

Another way to change schemas is through imagery. Clients are asked to relive painful childhood experiences and these are rescripted by bringing new characters into the story. For a client who recalls as a child being scolded by a teacher, the rescript might involve the therapist or the client as an adult coming in and talking to the child, asking about his/her feelings, offering comfort and actively correcting negative beliefs such as "you are bad … you are useless …your feelings and concerns are not important." The growing literature on imagery rescripting is documenting how effective it can be as part of the treatment of a large number of disorders including depression, social anxiety, OCD, eating disorders and many personality disorders (Arntz, 2011, 2012).

A related approach is through chair work. Different voices or parts of the self are allocated empty chairs. Clients sit on a chair and articulate the voice of each part. One chair may be for the child who believes she is unlovable and defective, another for a critical parent voice that is speaking disdainfully to the child, another for a coping mode such as emotional detachment, using alcohol or drugs, or escaping into watching TV or pornography. Chairwork can clarify the nature of the conflicts that prevent access to the schema level of childhood emotions and memories. It can also be used to provide the child with a corrective experience as in imagery rescripting described above. Depending on what is being worked with, chairwork may focus on rational evaluation, articulation and clarification, reviewing the role and value of coping strategies, or on engagement with the level of affective schemas and the problematic childhood memories they carry (Arntz, Bernstein & Jacob, 2013; Kellogg & Young, 2006).

Our models of assessment remind us that we need to understand both the predisposing and the maintaining factors that underlie the client's difficulties. The schema level, based on predisposing factors, embodies habits that are well entrenched and that mostly will not be changed by a single corrective experience. For change to endure, therapy also needs to promote new habits and experiences in current situations and relationships that reconfigure the maintaining factors. So, bottom-up interventions at the level of early maladaptive schemas, need to be complemented by top-down approaches designed to build new schemas in the here and now. In schema therapy this is called "building the healthy adult" and involves the kinds of cognitive restructuring and skill building methods that are usually associated with CBT. Thus, for a client who believes "I am unlovable, no one could possibly care about me" imagery rescripting of memories of childhood neglect can be complemented by examining the evidence from the client's life, logging data from everyday situations and looking at the evidence these provide, and performing behavioral experiments in which the belief is actively put to the test. In "strengths-based cognitive-behavioral therapy," Padesky and Mooney (2012) focus on helping clients identify existing strengths and expand them into new areas of their lives and so build resilience by developing new schemas. This approach "helps people with personality disorders construct and strengthen new systems of interpersonal strategies, core beliefs, and underlying assumptions" (Christine Padesky, personal communication, 11th June 2013).

Another present centered approach is to use emotion focused techniques to promote corrective experiences in current significant relationships. In EFT for couples (Johnson, 2009) and Attachment Based Family Therapy (ABFT) for depressed adolescents (Diamond, Siqueland & Diamond, 2003), the therapist works to help family members bypass avoidant and compensatory coping

and engage with each other at an emotional level in a manner that is empathic and respectful and that activates the genuine care and concern characteristic of secure attachment. There is growing evidence for the effectiveness of both these treatments.

As evidence accumulates for the value of both top-down and bottom-up approaches, there is often debate between those who champion one approach over the other. In practice, therapists need to be responsive to the unique context and presentation of each client and what s/he brings week by week (Edwards, 2013). This means attending to what a client is ready for, or motivated to do, to what is helpful and what is not, and using this awareness to tailor treatment to the individual on an ongoing basis. Where top-down approaches are, by themselves, ineffective, bottom up approaches that address early maladaptive schemas may provide the leverage that is needed to promote meaningful change. Where emotion focused techniques are destabilizing or fail to bring about change that generalizes to everyday situations, more emphasis on top down approaches may be appropriate. As clinicians, we face the daily challenge of responsively crafting interventions to the wide ranging needs of those clients we work with. In this process we can draw on and flexibly integrate top-down and bottom-up methods to bring about positive changes in early maladaptive schemas.

References

Ansbacher, H. L., & Ansbacher, R. R. (Eds.). (1958). *The individual psychology of Alfred Adler: A systematic presentation in selections from his writings*. London: George Allen & Unwin.

Arntz, A. (2011). Imagery rescripting for personality disorders. *Cognitive and Behavioral Practice, 18*, 466-481.

Arntz, A. (2012). Imagery rescripting as a therapeutic technique: Review of clinical trials, basic studies, and research agenda for personality disorders. *Journal of Experimental Psychopathology, 3*, 189-208.

Arntz, A., Bernstein, D. P., & Jacob, G. (2013). *Schema therapy in practice: An introductory guide to the schema mode approach*. Chichester, UK: Wiley.

Blatt, S. J., & Levy, K. N. (2003). Attachment theory, psychoanalysis, personality development, and psychopathology. *Psychoanalytic Inquiry, 23*, 102-150. doi:http://dx.doi.org/10.1080/07351692309349028

Diamond, G., Siqueland, L., & Diamond, G. M. (2003). Attachment-based family therapy for depressed adolescents: Programmatic treatment development. *Clinical Child and Family Psychology Review, 16*(2), 107-127.

Edwards, D. J. A. (2013). Responsive integrative treatment of PTSD and trauma related disorders: An expanded evidence-based model. *Journal of Psychology in Africa, 23*, 7-20.

Ellenberger, H. F. (1970). *The discovery of the unconscious: The history and evolution of dynamic psychiatry*. New York: Basic Books.

Greenberg, L. S. (2004). Emotion–focused therapy. *Clinical Psychology and Psychotherapy, 11*, 3-16.

Greenberg, L. S., & Safran, J. D. (1984). Integrating affect and cognition: A perspective on the process of therapeutic change. *Cognitive Therapy and Research, 8*(6), 559-578.

Johnson, S. M. (2009). Attachment theory and emotionally focused therapy for individuals and couples: Perfect partners. In J. H. Obegi, & E. Berant (Eds.), *Attachment theory and research in clinical work with adults* (pp. 410-433). New York: Guilford.

Kellogg.S.H., & Young, J. E. (2006). Schema therapy for borderline personality disorder. *Journal of Clinical Psychology, 62*(4), 445-458.

Kelly, G. A. (1955). *The psychology of personal constructs.* Volume 1: A theory of personality. New York: W. W. Norton.

Leventhal, H. (1979). A perceptual motor processing model of emotion. In P. Pliner, K. R. Blankstein & I. M. Spigel (Eds.), *Advances in the study of communication and affect, volume 5. Perception of emotions in self and others.* New York: Academic.

Oldfield, R. C., & Zangwill, O. L. (1942). Head's concept of the schema and its application in contemporary British Psychology. *British Journal of Psychology, 32*, 267-286.

Padesky, C. A., & Mooney, K. A. (2012). Strengths-based cognitive–behavioral herapy: A four-step model to build resilience. *Clinical Psychology and Psychotherapy, 19*, 283-290.

Sullivan, H. S. (1953). *The interpersonal theory of psychiatry*. New York: W. W. Norton.

Teasdale, J. D. (1993). Emotion and two kinds of meaning: Cognitive therapy and cognitive science. *Behavior Research and Therapy, 31*, 339-354.

Young, J. E. (1990). *Cognitive therapy for personality disorders: A schema-focused approach*. Sarasota FL: Professional Resource Press.

Young, J. E., Klosko, J., & Weishaar, M. E. (2003). *Schema therapy: A practitioner's guide*. New York: Guilford.

David Edwards from Rhodes University in South Africa is trained in Beck's cognitive therapy and is a certified schema therapist through the International Society of Schema Therapy. He has published over 70 academic articles and book chapters on a range of clinical topics including conscious and unconscious processes in psychotherapy, the use of imagery methods in psychotherapy, the history of imagery methods, case studies of the treatment of social anxiety and simple and complex PTSD, guidelines on the treatment of trauma related disorders, and case study as a research methodology. Email: d.edwards@ru.ac.za Website: www.schematherapysouthafrica.co.za