Combining EMDR and Schema Therapy: The Whole May Be Greater Than the Sum of the Parts

Updated from Young, J., Zangwill, W., and Behary, W. (2002).

A few days before his session, Dan had exploded again. A disagreement with his stepdaughter had led to another outburst during which he had cursed, slammed cabinet doors, and poisoned the family's weekend. After his outburst he had sulked for hours even though, as he later admitted, he knew he was overreacting.

The opening example illustrates a problem that has long concerned and frustrated many therapists and their clients. Why do intellectual awareness and insight not produce more significant emotional and behavioral improvement? Zajonc (1980) suggested this is because emotions and cognitions are processed in different areas and by different structures in the brain. The work of LeDoux (1989), Davis (1992), and others has shown that Zajonc was right: Emotional processing occurs through specific circuitry and structures in the brain. Unfortunately, much of clinical psychology has neither understood nor sufficiently integrated the treatment implications of this area of research.

This is problematic, because, as Rachman (1981) stated in response to Zajonc's article, "If words and techniques which are predominantly verbal in nature are inappropriate or at least insufficient media for entering the affective system or for modifying its functioning, we need to consider alternative modes and media (p.285)."

However, some practitioners have recognized the need for more integrative models of psychotherapy. Two of the best models are Young's (1990, 1999) Schema Therapy (ST) and Shapiro's (1995) Eye Movement Desensitization and Reprocessing (EMDR). Although these two approaches arose from different clinical experiences and theoretical backgrounds, they are similar in that they recognize the importance of all the ways in which people process information - affectively, physiologically, sensorially, as well as cognitively. Each model can be tremendously beneficial to clinicians and their clients. Combining aspects of each often yields better results than using either one alone. Thus, this chapter first includes a description of Young's model, and then an illustration of the way EMDR clinicians can enhance ST by using the powerful information processing aspects of EMDR. Last is a brief discuss of the way ST can also be valuable to EMDR clinicians.

The Schema Therapy Model

Young's ST (1995) was developed to expand Beck's original model of cognitive therapy. According to Beck, emotional problems were a result of biased evaluations made by clients. Beck believed that these distortions were a result of core assumptions made about the self and the world formed in early childhood. Thus, Beck's version of cognitive therapy focused primarily on correcting distorted patterns of thinking.

In contrast to analytic therapy, Beck's cognitive therapy assumed that these distortions could be brought into awareness relatively easily, and then challenged and corrected. Thus, his approach focused on increasing client's awareness of disturbing cognitions, and better understanding the connection between these distorted or maladaptive cognitions and painful emotions and behaviors. As awareness increased, it was assumed that clients could then test their hypotheses, gather evidence, and determine whether their cognitions were inaccurate or maladaptive. As clients disproved their mistaken underlying assumptions about themselves and the world, they could then replace these mistaken assumptions with more accurate or functional ones.

Although Beck's original model has had considerable success treating people with Axis I disorders, the limitations of standard cognitive therapy have become increasingly apparent as cognitive therapists have focused on more chronic, characterological clients. Young (1990) noted, that for Beck's model to be successful, a number of assumptions had to be met, and clients had to meet the following requirements:

1. Have the ability to access thoughts and emotions readily.

2. Be able to identify specific life problems.

3. Have sufficient motivation to do homework assignments.

4. Have cognitions flexible enough to respond to cognitive-behavioral techniques.

5. Be able to engage in open, positive relationships with their therapist.

6. Allow any difficulties that do occur in the therapeutic relationship, not to become a major problem focus.

Unfortunately, many clients cannot meet these criteria. As Young noted, the hallmark of more difficult clients, such as those with personality disorders or those who have been severely

traumatized, are the very factors that make Beck's standard model of cognitive therapy less effective for these clients. These characteristics include the following:

1. Interpersonal problems that make it difficult to engage in a positive therapeutic relationship.

2. Rigidity of thought, behavior, and emotion that make change difficult.

3. Diffuse presentation of problems.

4. Frequent avoidance of situations that might trigger disturbing thoughts, affect, and behaviors.

As a result of these limitations in the standard cognitive therapy model, Young developed ST. ST integrates cognitive, behavioral, experiential (e.g., Gestalt), and interpersonal (e.g., object relations) techniques using the concept of an Early Maladaptive Schema as the unifying element.

CONCEPTUAL UNDERPINNINGS

Young posited four constructs in his model: Early Maladaptive Schemas, Schema Domains, Schema Processes and Schema Modes.

Early Maladaptive Schemas

Segal (1988) conceptualized schemas as the residue of past reactions and experience that often effect subsequent perception and appraisals. In his work, Young focuses on a specific subset of these schemas which he refers to as Early Maladaptive Schemas. He defined these schemas as 'broad pervasive themes regarding oneself and one's relationship to others developed during childhood and elaborated throughout one's lifetime, and dysfunctional to a significant degree.' It is assumed that these schemas develop through an interplay of the child's innate temperament, everyday noxious experiences with parents, siblings, and peers, and the cultural context in which the child grows up. Schemas are representations of these early life experiences and serve as filters through which later experiences are processed. Thus, schemas contain patterns of distorted thinking, painful affect, and disturbing memories.

When triggered, schemas frequently generate high levels of affect. In an attempt to cope with these painful emotions, many clients develop behaviors that are ultimately self-defeating, such as addictive behaviors and avoidance. Because of the long-standing nature of many clients' problems and the painful affect associated with their schemas, ST focuses more attention on

creating affective experiences within and outside of the therapeutic relationship than does standard cognitive therapy. The model also recommends active confrontation of maladaptive cognitive and behavioral patterns.

As of this writing, Young has defined 18 EMS's, in addition to 5 hypothesized developmental domains (See Appendix 7). For example, people who were frequently criticized growing up often develop a Defectiveness/Shame schema with associated thoughts and feelings that they are defective, bad, or inferior, and would be unlovable if exposed.

Schemas are usually perceived to be irrefutable, which makes them difficult to change. They are intrinsically linked to people's concept of themselves and the world. Because they were formed so early in life, schemas are often ego-syntonic. Thus, even when presented with evidence that seems to contradict the schema, people often involuntarily distort data to maintain the schema's validity. For example, one client with a Defectiveness/ Shame schema felt more anxious after a promotion at work than before. Instead of seeing the promotion as disproving the Defectiveness Schema, this client felt that because the promotion, made him more visible and gave him more responsibility, it would only make people realize more quickly that he was indeed the flawed, inadequate person he believed himself to be.

Schemas are triggered under conditions relevant to a particular schema (e.g., a person with a Defectiveness/Shame schema asking someone out on a date, someone with an Abandonment/Instability schema confronted with a partner leaving to go on a business trip) or by biological changes such as PMS, sleep deprivation, etc.

SCHEMA DOMAINS AND DEVELOPMENTAL ORIGINS

In Young's model, the 18 schemas are grouped into five broad categories representing important aspects of people's core needs. These schema domains represent five universal developmental processes that often serve as the origin of schemas when blocked. Problems occur when a specific EMS in that domain interferes with people's attempts to meet their needs. For example, clients with Abandonment/Instability schemas (in the Disconnection and Rejection Domain) feel that sooner or later they will be abandoned by the people they care about and need. Thus, in every relationship abandonment is inevitable. Since it is only a matter of time until the abandonment occurs, clients with this schema may get anxious even when the relationship is going well. At the first sign of problems, they often become so needy and clingy, or angry, that they drive the other person away.

The use of the term 'schema' throughout the rest of this chapter will refer to an Early Maladaptive Schema.

The Five Schema Domains and Their Associated Schemas

Disconnection and Rejection

This domain is characterized by the expectation that one's needs for safety, security, acceptance, nurturance, stability, protection, empathy, and guidance will not be met consistently or predictably manner. The families of people in this domain were often detached, cold, rejecting, withholding, explosive, unpredictable, or abusive. Schemas in this domain are: Emotional Deprivation, Mistrust/Abuse, Emotional Inhibition, Defectiveness/Shame, and Social Isolation/Alienation.

Impaired Autonomy and Performance

Clients in this area have fears about themselves and the environment that make it difficult for them to separate, survive, function independently, or be successful. These schemas include: Dependence/Incompetence, Abandonment/Instability, Vulnerability to Harm or Illness, Enmeshment/Undeveloped Self, Failure, and Subjugation. Clients with these schemas typically grew up in an enmeshed, overprotective, or undermining family that either failed to reinforce them for performing competently or neglected to foster skills needed for independent functioning.

Impaired Limits

This domain includes schemas of Entitlement/Grandiosity and Insufficient Self-Control/Self-Discipline, and pertains to a deficiency in internal limits, responsibility to others or long-term goal orientation. Individuals with these schemas have difficulty in respecting the rights of others, cooperating, making commitments, or setting and meeting realistic goals. Clients with these schemas typically come from families that were permissive, indulgent, unstructured, or felt superior to others, and did not effectively discipline their children or set appropriate limits.

Excessive Responsibility & Standards

Excessive emphasis on meeting strict, internalized rules and expectations about performance across many aspects of life. These may include an excessive focus on responsibility to others, orderliness, duty, or proper behavior -- often at the expense of one’s own happiness, self-expression, relaxation, close relationships, or health. Typical family origin is demanding, critical,

and sometimes punitive, with very high standards; or the expectation that the child should sacrificehis/her own needs most of the time to take care of others. May involve feelings of guilt or selfishness when engaging in positive or enjoyable activities purely for oneself. Exceptional achievement, meeting responsibilities, perfectionism, taking care of other people at the expense of oneself, adhering rigidly to ethical and moral principles, following rules, "stoicism", and avoiding mistakes predominate over pleasure, joy, and relaxation. Some individuals expect others to meet their own unrealistically demanding sense of responsibility and standards.

Unclassified Schemas

Schemas in this domain include: Approval Seeking/Recognition Seeking, Negativity/Pessimism, and Punitiveness.

SCHEMA PROCESSES

As mentioned previously, ST is a method of treatment involving active confrontation of clients' underlying schemas and associated distorted cognitions, painful affect, and maladaptive behaviors. Treatment involves confronting clients' various maladaptive affective, cognitive, and behavioral coping strategies, which are referred to as schema processes. Clients engage in these processes to avoid, or to compensate for, the painful affect associated with the triggering of schemas. The three schema processes are Schema Avoidance, Surrender, and Overcompensation. Avoidance and overcompensation overlap with the analytic concept of defense mechanisms.

Schema Avoidance

This process refers to any type of attempt by clients -through cognitive, affective, or behavioral avoidance - to avoid triggering the painful affect associated with a schema. For example, clients with a Vulnerability to Harm and Illness schema may avoid leaving home for fear they will be harmed. Of course, this avoidance precludes any possibility that clients can experience being safe in the world, and, thus, disprove the schema.

Although avoidance behaviors can be frustrating to clinicians and clients, if clinicians understand their clients' schemas, the avoidance makes sense. For example, if clients think and feel the world is unsafe (Vulnerability to Harm and Illness Schema), it makes sense for them to stay at home. If they feel that as soon as other people realize who they really are, then they will be disgusted, turned off, and want to leave them (Defectiveness/Shame and Abandonment), why should such clients risk being vulnerable in a relationship?

Schema Maintenance (Surrender)

Maintenance is a process by which clients repeats old, familiar ways of thinking, feeling, and behaving (often, unconsciously) to perpetuate the schema. For example, clients with a Self-Sacrifice schema might repeatedly get involved with one alcoholic after another, thus perpetuating their excessive taking care of others. We refer to maintenance as “surrendering” to the schema.

Schema Compensation (Overcompensation)

This is a process in which clients attempts to overcompensate for, or fight, the schema. It is often an early attempt by children to adapt to their pain. Like the other processes, compensation is probably adaptive in childhood. However, when it persists into adulthood, it often backfires and perpetuates the schema. For example, some clients with very critical parents might become critical of others; and, thus, be drawn to partners that they can criticize. By being around others who are ‘even more defective’ than they are, clients decrease the risk that their own Defectiveness/Shame schema will be triggered. However, being with a partner they feel is defective is likely to be very unsatisfying. Thus, continuing this pattern with others later in life is likely to prevent clients from getting the closeness and connection they want and need.

SCHEMA MODES

So far, Early Maladaptive Schemas, Schema Domains, and Schema Processes have been discussed. The latest concept in ST is Schema Modes. Although most clients have a number of different schemas, at any given time, some are active, and others are dormant. A schema mode is the group of currently active schemas, schema processes or both. Thus, a schema or schema process is a trait concept, whereas a schema mode is a state concept. Young defined a schema mode as a facet of self, involving a natural grouping of schemas and schema processes that has not been fully integrated with other facets. [For details see Young & Behary (1998).]

APPLICATIONS OF SCHEMA FOCUSED THERAPY: ASSESSMENT AND EDUCATION

ST is composed of two phases: assessment and education, and change. As is discussed later in this chapter, EMDR is very useful in both phases. In the assessment phase, the focus is on identification and activation of each client's schemas, and schema processes most often used, such as determining which problems clients are having, which underlying schemas the problems represent, and in which maladaptive ways clients are coping with their issues.

During this phase, clinicians also educate clients about ST and gather various types of information to understand the case. This phase includes activities common to all good psychotherapy including history-taking, mental status, and problem identification. Components of this phase specific to ST include: schema identification, schema activation, schema conceptualization, and schema education.

Schema Identification

Clients' schemas are identified in numerous ways. During the initial sessions, clinicians look for early, ongoing patterns connected to clients' presenting problems. Clinicians also pay close attention to interactions in the therapy relationship. The use of questionnaires such as the Young Schema Questionnaire (Young & Brown 1990/1994) a self-report inventory with items related to each schema, and the Young Parenting Inventory (Young, 1994) are designed to help clinicians and clients identify life patterns. The Multimodal Life History Inventory, which collects essential historical material (Lazarus & Lazarus, 1991) is used to collect a broad range of information as efficiently as possible. The Multimodal Life History Inventory often provides valuable positive information, such as details about educational or vocational achievements, or good relationships, -- that can be used as evidence later in treatment to combat some of clients' negative views of themselves, others, and the world.

Schema Activation

The goal of schema activation is to determine experientially which of the clients' schemas are most powerful (and, thus, need to be addressed first); to ascertain how well clients can handle affect; and, through this experiential process, to help educate clients about the emotions associated with their schemas.

Schema Conceptualization and Education

All of the material gathered during the assessment phase is integrated into an overall picture of clients' problems and shared with them. This process may occur within the first few sessions or may take several sessions depending on how fragile, wounded, or avoidant each client is.

Before the active change phase begins, it is essential to explain to clients the initial conceptualization in schema terms: the reasons they are having problems and the purpose of your recommendations. This sharing of information helps establish a collaborative relationship, enables clinicians to get feedback from clients, and serves as a rationale for later recommendations for change by clinicians. To further clients’ understanding of ST, therapists

often recommend they read 'Reinventing Your Life' (Young & Klosko, 1993), a self-help book based on the schema-focused approach.

At this point in treatment, clinicians have identified clients' primary schemas and coping styles (the primary schema processes they use); completed a full assessment of clients' problems; established a collaborative relationship; educated clients about schemas; and helped them to experience emotionally how the schemas are affecting their lives.

APPLICATIONS OF SCHEMA THERAPY: CHANGE

ST combines cognitive, behavioral, interpersonal, and experiential techniques to produce change in many different dimensions.

Cognitive Techniques

Cognitive strategies are designed to increase clients' awareness of their distorted views of themselves and others, and to gather evidence to refute these distorted viewpoints. Thus, throughout treatment, clinicians help clients gather evidence to contradict their distortions (as embodied in the various schemas).

When asked to provide data to contradict their schemas, many clients struggle to find contradictory information. Using information gathered from the various instruments mentioned previously and clinicians' experiences with clients, clinicians may need to suggest examples. For example, for a client with the Emotional Deprivation schema, clinicians may suggest the following, "I know you feel that you never got the nurturing and understanding you needed from your parents, but how did you and your brother and sisters get along when you were growing up?"

As with all cognitive techniques, clinicians should introduce information that will challenge clients' current schemas.

Clinicians also want to extend the progress made during the session and apply it to clients' daily environment. One of the ways this is done is with flashcards (Young & Klosko, 1994).

ST clinicians are always looking to challenge clients' underlying maladaptive assumptions about themselves and the world. Like good lawyers, good clinicians never ask questions like this unless they already know that there is a good answer, e.g., "Well we have always been close, and I know they would be there for me if I needed them." If clients were an only child or did not have a good relationship with their siblings, clinicians can substitute any person who did provide care and nurturance. This could include grandparents, teachers, lovers, close friends,

etc.

Flashcards are used to help clients continue this process outside of the therapy session. The flashcard lists the evidence against the schema and is carried by clients on a piece of paper, an index card, or an audio tape. Clients are encouraged to review the 'evidence' daily and whenever their schemas are activated.

This frequent review of a rational response acts as a self-control device to reduce the frequency of dysfunctional behaviors, and, also, helps clients gain some distance from and perspective about the schema and its associated thoughts, feelings, and body sensations. The flashcard thus contradicts clients' habitual ways of thinking and continues the therapy between sessions. For example, Dan, who was mentioned at the beginning of this chapter, lost his temper when he felt unappreciated and criticized. The following flashcard was developed for him to use whenever he felt unappreciated or that he was about to lose his temper.

“I know I'm feeling incredibly angry that once again I'm being taken advantage of and that no matter what I do I will never be good enough, *but* while some people may not appreciate me, I do have people in my life who genuinely care for me and appreciate what I do. My wife thinks I am wonderful and shows her appreciation all the time. At work, I just received an excellent evaluation and raise. While I'll never be perfect, I have gotten better at controlling my temper and can continue to do so.”

Experiential Techniques

Although cognitive techniques can be very valuable for helping correct clients' distortions, their effectiveness can be limited for the reasons mentioned at the beginning of this chapter - cognition and affect are processed in separate systems. Thus, at various points in therapy, many clients have said that they rationally 'believe' the more positive cognitions they have worked on, but that this belief does not seem to help how they feel or behave.

For this reason, we have focused on incorporating experiential techniques into ST and have found that they are often the most useful of all strategies. In fact, these experiential techniques are required to weaken the strength of the underlying schemas of many clients. Three of the most commonly used experiential techniques are imagery, schema dialogues, and EMDR.

Imagery

As we mentioned previously, imagery is used in the assessment phase to help clients connect present problems to past experiences, and to probe for underlying schemas. In the change phase, clients work on changing unpleasant images. For example, clients with the Emotional Deprivation schema would be asked to close their eyes and bring up an early time in their lives when they felt deprived or not understood by a parent. They are then asked and coached by clinicians to communicate their feelings and needs to that parent in the image. With as much support and coaching as clients need, they are encouraged to state their rights as children to be loved, understood, and nurtured.

Facing the painful image of the depriving parent enables clients with this schema to better understand parents' roles in the formation of their schemas and to be fairer to themselves. In EMDR terms, this helps clients to assign appropriate responsibility (i.e., to the parent) for their issues and to realize that they have more choices now than they had in the past.

Schema Dialogue

With schema dialogues, clients learn to confront the feelings elicited by the schema, and to support and strengthen the healthy aspects of themselves. For example, clients with the Defectiveness schema can be taught that although they 'feel' defective or worthless at a core level, some part of themselves (which is called the 'healthy adult'), even if initially small, can integrate evidence that they are worthwhile and do not have to feel ashamed.

In the schema dialogue, clients are asked to refute the schema by providing evidence that negates it. Refuting the schema is often difficult for many clients. Therefore, clients are initially asked to role play the schema, (i.e., to say out loud thoughts consistent with a particular schema). For example, a client role playing a Defectiveness schema might list some of the following statements:

1. "Why do you keep trying in relationships? You know sooner or later anybody you get involved with will realize what a loser you are.

2. “You’re never going to be successful, because you just don’t have it.”

3. “I can’t believe you haven’t been found out for the fraud that you are. It is just a matter of time until you are.”

Clients are usually able to play the schema side with ease. Though often when they hear their

statements, they begin to realize how unfair they are to themselves.

Although the initial dialogue is easy for many clients, the next phase is not. In the second phase, clients are asked to respond to a schema using their "healthy side." Clients often experience more difficulty in this phase because it requires them to access information that negates the schema; information that they typically minimize. Clinicians often need to coach clients by supplying them with dialogue that supports a more balanced, less pernicious view of the self. For example, Dan, who lost his temper with his stepdaughter at the beginning of this chapter, had highly critical parents. He brought up a very distressing memory of an event that occurred when he was 8 years old. In the following transcript, comments in [brackets] indicate editorial points of interest.

T: "Dan, bring up that image of you when you were 8 and had just finished cleaning up the house and your mother standing there criticizing you. Tell her how you are feeling."

D: "I don't know what to say. I know it made me feel bad when she criticized me, but she was usually right. I did make mistakes. One time, I remember she was furious because I had forgotten to clean the baseboards." [This is an example of how hard it can be for clients to be fair to themselves in the present because of the negative beliefs contained in the schema. Dan's Unrelenting Standards schema is causing him to judge his 8-year-old behavior by adult standards. When this happens, clinicians often need to step in and actively coach clients.]

T: "Tell her that you tried as hard as you could. That you are only 8 years old, and that you need her support."

Dan: "Mom, I tried as hard as I could; but, when you criticize me, it makes me feel like a complete failure. I'm only 8; I need you to say something nice."

This dialogue helped Dan realize that it was not his fault that his mother had criticized him. Her criticism did not mean that he was defective. In this case it meant that she was unfair. These schema dialogues often help clients to both distance themselves from the schema and to realize that the schema can be changed. With sufficient practice, many clients report an increased ability to respond in healthier ways when their schemas are triggered.

Interpersonal Techniques within the Therapy Relationship

As analysts have discussed for decades, many of clients' schemas emerge in the therapeutic relationship. Therefore, addressing issues that emerge in the relationship between client and

clinician is important for identifying and modifying those schemas. In ST, clinicians work openly with clients on identifying and modifying schema-driven thoughts and feelings. This may involve limited self-disclosure on clinicians' part to correct distorted beliefs and expectations clients may have. Though sometimes painful to hear (especially when clients are correct about something the therapist has or has not done), it is important to allow clients to express these beliefs and feelings in the session.

For example, any time therapists go away on vacation or to a conference, clients with Abandonment schemas are likely to become very upset and angry at the therapist. Therefore, it is important to discuss these feelings during the session, to reassure clients about the therapist's return, but also to honestly talk about the therapist's need for rest and rejuvenation. To do this, ST therapists use what Young refers to as 'empathic confrontation' as their primary working stance with clients. Therapists fully acknowledge and validate clients' feelings and concerns, while gently pointing out other, more accurate views. For example, a therapist going on vacation would empathize with client's distress and pain, and fully acknowledge the pain of the separation. In the same session the therapist would tactfully point out past times when they have left and returned, and how much they enjoy working with clients (if true). This last bit of reassurance is crucial for clients who worry that clinicians will abandon them because their clinicians do not like them.

To use interpersonal techniques appropriately, therapists need to acknowledge that they may have issues that may need to be addressed. The more clinicians are aware of their own schemas, the more effective their work will be. The clinical experiences of the authors of this chapter as well as our supervision of others, strongly suggest that clients who trouble us the most are the ones who trigger our own unresolved schemas.

Behavior Change Techniques

As important as in-session work is, the ST therapist assumes that work needs to be done outside of the session to break self-defeating patterns of behavior such as avoidance, surrender, and overcompensation. Well-established behavior change techniques, such as role play, are used to provide corrective experiences for each client.

Weaving Together ST and EMDR

ST is a complete therapeutic method. As effective as it is, it can be even more effective when combined with EMDR. This section shows some of the ways in which EMDR can increase ST's effectiveness, and how the two approaches complement each other.

As we mentioned previously, ST has two major phases: Assessment and Education, and Change. This section uses our work with Dan to illustrate many of the ways in which EMDR can enhance the power of ST in both phases.

Dan was a 60-year-old executive. He sought treatment partly because of his wife's concerns about his temper. She reported that periodically, when things did not go his way, he would become explosively angry. Although he had never hit her or his stepchildren, his violent cursing, door slamming, and hours of sulking, scared her and had ruined many family gatherings. When interviewed, Dan agreed with his wife's description of his behavior, but reported that he had no idea why he got so angry. He acknowledged that the intensity of his rage seemed out of proportion to what happened.

Assessment and Education

In the initial stages of treatment (Assessment and Education), Dan was given the Multimodal Life History Inventory, the Young Schema Questionnaire, and the Young Parenting Inventory. Information obtained from these instruments, and from discussions with Dan revealed the potential presence of numerous schemas, including Defectiveness/Shame, Self-Sacrifice, and Unrelenting Standards. However, efforts to trigger these schemas during a session through discussion and through imagery were unsuccessful. Dan had a difficult time getting in touch with any feelings - especially those feelings from past events. "What's the point of digging up this old stuff?" was one of his responses. Thus, although he had an intellectual understanding of his issues and schemas, little, if any, affective connection was made. The therapist decided to use the Target Assessment Questions from EMDR to try and increase his emotional understanding of how his past experiences were affecting him in the present.

The EMDR Target Assessment Questions are designed to help clients access information on many different dimensions - visually, cognitively, affectively, and physiologically. Using any client problem - past, present, or future - the therapist helps clients develop a visual image of the most disturbing aspect of the problem, identify the negative cognitions clients have about themselves in regard to that problem or event, and note both the emotions that are triggered and experience the bodily responses that occur when this information is accessed. Using these different dimensions often help clients feel the power of their schemas; thus, making the education process much easier. It also allows both clinicians and clients to identify the most powerful (painful) schemas, check for processes such as avoidance, and alert clinicians to possible modes. Because Dan had lost his temper recently, the therapist had him focus on that event and used the EMDR Target Assessment Questions.

TARGET ASSESSMENT QUESTIONS

1. Defining the problematic memory or issue:

T: "Dan, please describe that last time you lost your temper?”

Dan: "Well, the night after we had a lot of snow, my stepdaughter's car was stuck in the driveway. I offered to help her get it unstuck and went outside and started shoveling. Not only did she not come out and help, but at one point, she stuck her head out the door and asked if I were done yet. When she asked that, I just lost it.

2. Obtaining a vivid picture representing the memory or issue in the present:

T: "What picture represents the worst part of that incident NOW?"

Dan: "I see myself standing in the driveway, sweating like crazy, as she's standing in the doorway asking if I am almost done."

3. Developing a negative cognition:

T: "What words go best with that picture that express your negative belief about yourself now?"

Dan: "I'm not good enough."

4. Developing an alternative positive cognition:

T: " When you bring up that picture of standing in the snow as she is asking if you're done, what would you like to believe about yourself, now?"

Dan: "I am good enough."

5. Rating the emotional validity of the positive cognition:

T: "When you think of that picture, how true do those words, I am good enough, feel to you now on a scale of 0 to 10, where 0 feels completely false and 10 feels completely true?

Dan: "About a 2."

6. Help clients access emotions.

T: "When you bring up that picture of your stepdaughter standing in the doorway asking if

you're done yet and those words, "I'm not good enough", what emotions do you feel now?"

Dan: "Sheer rage..."

7. Accessing body sensations:

T: "Where do you feel the disturbance in your body?" Dan: "In my throat, chest and gut."

8. Measuring the subjective units of disturbance (SUDS) for this issue or memory:

T: "And how upsetting does that incident feel to you now, on a scale of zero to ten, where zero is no disturbance or neutral, and ten is the highest disturbance you can imagine?"

Dan: "About a nine."

For many therapists, each of Dan's responses might have engendered more questions and discussion. However, in EMDR, most of the time moving through the questions without digression is the most effective way to help clients access this material on so many different dimensions.

Naturally, time is provided to explain and discuss any questions clients have or any issues that arise before and after the EMDR process.

At this point, Dan was surprised at the amount of distress he felt. By using the EMDR Target Assessment Questions, he was able to *feel* how disturbing the event still was. The therapist continued the evaluation to determine if this was a one-time event or part of a pattern linked to his Defectiveness/Shame schema. To do this, the therapist used the 'Floatback Technique' (Browning, 1999). Like the 'affect bridge' used in hypnosis (Watkins, 1992), this technique is designed to help clients connect present problems to past events.

Floatback Technique

ST and EMDR assume that one of the reasons events in the present are so disturbing is that they often activate previous, still painful memories. This often happens in a session when clients' responses seem out of proportion to an event they are describing, (i.e., when an event has 'hit a nerve.') In ST, the nerve is called a schema; in EMDR it is called opening a childhood file folder in which painful information resides (Shapiro, 1995). The float back technique is a strategy for activating a specific problem as vividly as possible to determine if a schema has been activated and a method for educating clients about the way this problem is connected to

past experiences. Once the material is activated, clients are encouraged to think of other, similar occurrences. Following is additional therapy with Dan used to illustrate this technique.

Therapist: "Dan, at this point, please bring up that image of standing sweating in the driveway as your stepdaughter asks you if you're done yet; and those negative thoughts of, 'I'm not good enough'. Notice what emotions are coming up for you and where you are feeling them in your body. Now, just let your mind 'float back' to an earlier time in your life where you had similar thoughts, feelings, and bodily sensations, and tell me what comes up for you"

Dan: "I see this picture of me when I was about 8 years old, cleaning the house trying to get my mother's approval. But no matter what I did, she always found something to criticize. No matter what I did or how hard I tried, I was never good enough."

It is clear that we have activated Dan's Defectiveness/Shame schema as shown by his statement of, "I was never good enough." By calling his attention to the different ways in which information is stored -- his disturbing visual images, negative cognitions, upsetting affect, and painful body sensations, the therapist also educated him about schemas and their pervasiveness throughout the information processing system. Once Dan felt how upsetting these events still were to him, he needed very little additional information to be convinced about the importance of schemas. Although many ways can help activate clients' schemas, many therapists who combine ST with EMDR have found the EMDR Target Assessment Questions combined with the Float Back technique to be a very effective way to do so.

Most of the time, the Target Assessment Questions activate clients' information processing networks very effectively, and they can feel the power of a particular schema. However, some problematic clients are not initially able to tolerate affect, and, instead, engage in significant affective and cognitive avoidance when clinicians attempt to activate their schemas. Clients may not be able to, or may refuse to, engage in imagery procedures or answer the therapist's questions directly. In more severe cases, clients may dissociate when painful material arises. For clients who have difficulty tolerating increased affect, other procedures borrowed from EMDR have proven to be very helpful to the ST/EMDR clinician. Two such procedures are The Safe Place Exercise and Resource Development and Installation.

Safe Place Exercise

To do ST and EMDR well often demands that clients experience a significant amount of affect both within and between sessions. Clients who have been severely traumatized or who by temperament are somewhat fragile may be overwhelmed if steps are not taken to protect

them. The safe place exercise is used to create an imaginary refuge for these clients. Clients are instructed to imagine a place where they feel safe. Ideally, this place currently exists and is accessible to clients -- such as a beach, on a couch with a partner or friend, or with a pet. If no such place is currently available, clients can use a safe place from the past such as memories of being with a loving grandparent or former partner. For clients who do not have any positive memories from the past, clinicians can help clients create an image of the safe place that they would like to have. When painful affect becomes too intense, clients can imagine being in their safe place and decrease the pain. Having a safe place allows clients to modulate the amount of affect they are experiencing. This increased ability to tolerate affect is crucial in ST and EMDR, because clients who avoid thoughts, memories, or situations that trigger their significant schemas are not likely to make much progress.

Dan's safe place was on the beach in the Caribbean with his wife. He imagined lying on the beach, listening to the sounds of the waves and smelling the air, while his whole body relaxed. After creating this image, the therapist asked him to close his eyes and vividly recall this scene to ensure it really did make him *feel* safe and relaxed. With a broad smile on his face, Dan mentioned that the only problem with the image was that it was so nice that it made him want to leave the session and go there.

Resource Development and Installation

Although the safe place helps many clients decrease anxiety, some clients do not have the ability to develop one in the initial stages of treatment. For these clients, another procedure borrowed from EMDR, Resource Development and Installation (RDI) (Leeds, 1998) has been used with clients to help them tolerate increased levels of affect and to increase their feelings of self-efficacy.

During RDI, clients are initially asked to focus on the place where they are stuck and the qualities that they lack to succeed. Using a step-by-step process, clients are then asked to think of a time, either in the present or past, when they had those qualities. When clients cannot do this, they are asked to think of a person they admire, real or imaginary, who could help them surmount their problems. These images are then used to generate an image of success on a cognitive, affective, and physiological level. To enhance the power of this image, eye movements are used repeatedly. Thus, RDI combines images of success with eye movements to strengthen clients' beliefs that they can succeed. Initially, Dan could not imagine expressing his needs to anyone without being criticized or dismissed. His resource was to imagine a favored older sister standing with him putting her arm around his shoulder and giving him

encouragement.

Thus, during the assessment and education phase of ST clinicians frequently use aspects of EMDR, especially the Procedural Step Questions and the Safe Place Exercise, to help them determine which schemas need to be addressed; to educate clients; and to increase clients' ability to tolerate painful affect.

EMDR in the Change Phase of Treatment

For many ST clients, the change techniques described previously (e.g., flashcards, imagery, schema dialogue,) are very effective. For some clients, they are not. For example, the therapist tried schema dialogue and asked Dan to tell his mother what he needed. With significant prompting, he was able to say the words, but he later told us that even though he knew the words were true intellectually, i.e., that his mother should have been more supportive and less critical, he did not really feel the words to be true emotionally. Even after the schema dialogue was repeated several times, along with schema mode work, he still felt that on some level his mother was right - that he had not been good enough. However, when the therapist used EMDR during the same scene - his mother criticizing the efforts he had made to clean the house - Dan reported that he felt his thoughts and feelings change for the first time. At the end of the EMDR processing, Dan reported feeling much less guilt and shame and the realization that he had done the best he could. EMDR seemed to connect what he knew intellectually with what he felt emotionally.

T: "Dan, bring up that picture of your mother criticizing you when you were 8 for the way you had cleaned the house; those negative thoughts that 'I'm not good enough'; notice where you are feeling it in your body and follow my fingers." (These instructions were then followed by a set of eye movements.)

D: (Turning red in the face with tears coming to his eyes) "I can't believe it. No matter what I did, it was never good enough for her."

As the sets of eye movements continued, Dan's Defectiveness/Shame schema played itself out in numerous ways. One of the most interesting was that, as he started to feel less pain from that specific event of being criticized at 8, he then blamed himself for letting it bother him so much.

D: "What kind of wimp am I for letting this bother me so much? I mean this was 50 years ago."

As therapy continued, Dan became increasingly aware of how unfair this situation had been; how much it still bothered him, though less so than before the EMDR; and how connected it was to his current issue of losing his temper whenever he felt criticized. (The criticism, of course, triggered his underlying feelings of defectiveness and shame, hence producing the anger.)

During the next few sessions, Dan reported several changes. For the first time he realized, emotionally, that he had been a pretty good kid. He also reported that the event felt further away and less intrusive to him (a common response after EMDR processing.) At a joint session with his wife, she reported an even more surprising event. She said that while on vacation the previous week, Dan had been late meeting her. She said in the past, if she would have said anything at all to him about being late, he might have flown into a rage and ruined the rest of their day. This time, when she gently mentioned it, Dan apologized. He did not get angry or sulk. On hearing his wife describe this event, Dan laughed and said, "You know, she's right. In the past I probably would have blown up; but now, I wouldn't have even remembered it if she hadn't said something now."

Thus, EMDR connected cognition with affect, lessening the pain from the past event and reducing the strength of the Defectiveness/Shame schema. Using EMDR to make this connection allowed more adaptive information to be internalized, e.g., my wife was a little irritated with my being late, but she does not think I am a horrible person. Clients often report that after EMDR their schemas feel weaker.

Behavior Change

After the schemas have been weakened during a session, clients still need to make changes in their natural environment, which is why both EMDR and ST have behavior change components. However, before giving an assignment to be completed outside of the session, EMDR can be used to effectively anticipate obstacles that might arise and to reduce clients' anxiety, thus, improving their chances of success. Essentially this is using EMDR for imaginal desensitization prior to in vivo exposure. In EMDR, this is called the 'Float Forward' technique (Browning, 1999).

Float Forward The Float Forward technique uses the previously described Target Assessment Questions with one important change. When therapists ask for clients to think of an image of their changing, the therapist asks them to imagine the worst thing that could happen. This image is designed to uncover and successfully address any anticipatory anxieties clients may have.

This technique encourages clients to face their fears and help them and their clinicians to devise solutions or better coping strategies for problems that might arise. In Dan's case, he had made significant improvement, but he still had some anticipatory anxiety about situations regarding his blended family, especially his stepdaughter. As a holiday gathering was approaching, the therapist used the float forward technique to have Dan picture his worst fear.

T: "Dan, bring up that image of sitting around the dinner table with your family. What is the WORST thing that could happen?"

D: "I see my stepdaughter making some negative comment about the way the house looks, and I just explode. And then, everybody gets mad at me for losing my temper."

The therapist completed the rest of the Target Assessment Questions and began eye movements with this scene.

D: "I feel so hurt that she would be so critical. Doesn't she know how hard I've tried to be a good provider for her mother?"

More eye movements.

D: "This is weird. She is my stepdaughter, but I'm reacting to her just the way I did to my mother. She's barely out of college and I'm trying to get her approval, so I can feel good about myself."

As the processing continued, Dan realized how old and familiar this pattern was. It connected with a number of memories in which he felt he had not been good enough - situations primarily involving his mother, but also including other people, (e.g., at work).

After this material had been processed, Dan reported decreased anxiety about the upcoming dinner. The therapist asked him to imagine the same scene and developed a positive future template in which he responded differently to his stepdaughter's criticism.

D: "I see the same scene with her criticizing the house, but this time I realize that she is really just a kid, and I don't need her approval."

Again, the therapist had Dan develop the image, elicit his negative and positive cognitions, notice which emotions were being triggered and where he felt them in his body. The therapist then used eye movements until Dan reported, very confidently, that he could handle his stepdaughter's criticism without losing his temper. Thus, the use of EMDR helped decrease his

anticipatory anxiety and provided effective cognitive rehearsal.

When clients can imagine themselves successfully completing the appropriate task, they are asked to try out the new behavior between sessions. (Note: It is recommended that when giving behavioral assignments that both clinician and client adopt an investigative stance regarding making changes. Change is hard and clients are unlikely to be completely successful. Setting realistic expectations and giving reassurance that change is a process and not a test can help reduce client anxiety.)

ENHANCING EMDR WITH ST

As discussed, EMDR can be very helpful to ST/EMDR therapists. As much as EMDR can help the ST therapist, ST can be equally valuable for the practicing EMDR therapist. Early recognition of clients' schemas and maladaptive coping styles will enhance the effectiveness of the EMDR in various ways in every stage of EMDR treatment. For example, in the EMDR phase known as Target Assessment, clinicians attempt to have clients develop appropriate Negative and Positive Cognitions specific to each problem. However, clients often do not provide 'perfect' cognitions. Knowing clients' schemas can be crucial in guiding clinicians. For example, it is recommended that clinicians be more lenient and supportive of clients with a Defectiveness/Shame schema than they might be with other clients. Trying too hard to get a perfect cognition with these clients may activate their sense of defectiveness and inhibit EMDR processing.

Similarly, during the Desensitization Phase when the bilateral stimulation has commenced, therapists periodically stop the stimulation to allow clients to report what kind of processing is occurring. During these pauses, some clients will talk for an extended period. Even experienced EMDR clinicians often wonder whether they should interrupt clients to resume the bilateral stimulation and, if so, when? ST principles make the decision much easier. For example, if a client has an Emotional Deprivation schema and has seldom felt heard or understood, then it is recommended that the EMDR clinicians listen longer than they might normally. On the other hand, if clients are using their words to avoid unpleasant images, affect or cognitions, then EMDR clinicians are encouraged to interrupt this avoidance process and resume processing (while providing a great deal of support, of course.) Thus, the way a clinician should respond while using EMDR can be greatly facilitated by a thorough knowledge of ST.

In summary, Zajonc and Rachman were right. Cognitive information and affective information are processed in different areas of the brain (Zajonc) and alternative modes of therapy are needed to access information across a variety of systems (Rachman). By deliberately focusing

on the variety of ways in which clients store and process information - sensorially, cognitively, affectively, and physiologically -Young's Schema Therapy and Shapiro's Eye Movement Desensitization and Reprocessing are two therapies that do just that.

Early Maladaptive Schemas and Schema Domains (Revised January, 2014)

Disconnection and Rejection

1. Emotional Deprivation

Expectation that one's desire for a normal degree of emotional support and connection will not be adequatelymet by others. The three major forms of deprivation are:

- *Deprivation of Nurturance*: Absence of attention, affection, warmth, or companionship.
- *Deprivation of Empathy*: Absence of understanding, listening, self-disclosure, or mutual sharing offeelings by others.
- *Deprivation of Guidance & Protection*: Absence of strength, direction, or guidance from others.

2. Mistrust / Abuse

The expectation that others will hurt, abuse, humiliate, cheat, lie, manipulate, or take advantage. Usually involves the perception that the harm is intentional, or the result of unjustified and extreme negligence. Mayinclude the sense that one always ends up being cheated relative to others or "getting the short end of the stick."

3. Emotional Inhibition

The excessive inhibition of spontaneous action, feeling, or communication -- usually to avoid disapproval byothers, feelings of shame, or losing control of one's impulses. The most common areas of inhibition involve: (a) inhibition of *anger* & aggression; (b) difficulty showing *affection and love*; (c) difficulty *sharing private feelings* or discussing emotional issues; (d) inhibition of *positive impulses* (e.g., joy, sexual excitement, play); (e) difficulty expressing *vulnerability,* or communicating one's feelings and needs to others; or (f) excessiveemphasis on *rationality* while disregarding emotions.

4. Defectiveness / Shame

The feeling that one is defective, bad, unwanted, inferior, or invalid in important respects; or that one wouldbe unlovable to significant others if exposed. May involve hypersensitivity to criticism, rejection, and blame; self-consciousness, comparisons, and insecurity around others; or a sense of shame regarding one's perceived flaws. These flaws may be **private** (e.g., selfishness, angry impulses, unacceptable sexual desires)or **public** (e.g., unattractive physical appearance, social awkwardness.

5. Social Isolation / Alienation

The feeling that one is isolated from the rest of the world, different from other people, and/or not part of anygroup or community. May include a sense that one is an outcast, doesn't fit in, or has been excluded by a group, community, or the world at large.

Impaired Autonomy & Performance

6. Dependence / Incompetence

Belief that one is unable to handle one's *everyday responsibilities* in a competent manner, without considerable help from others (e.g., take care of oneself, solve daily problems, exercise good judgment, tacklenew tasks, make good decisions). Often presents as helplessness or anxiety, especially in new situations.

7. Abandonment / Instability

An exaggerated fear that the people one relies on most for security, connection, and help will suddenly abandon you forever, leave you alone for long periods of time, or not be available when you need them. Fearof abandonment may be exacerbated by the feeling that one will not be able to function or survive in life without the assistance of "significant others."

Often involves the expectation that others will not be available to provide emotional support, strength, orprotection on a consistent, ongoing basis. Other people may be viewed as emotionally unstable, unpredictable, unreliable, or not consistently available.

8. Vulnerability to Harm or Illness

Exaggerated fear that *imminent* catastrophe will strike at any time, and that one will be unable to prevent it.Fears focus on one or more of the following: (A) *Medical Catastrophes*: e.g., heart attacks, AIDS; (B) *Emotional Catastrophes*: e.g., going crazy, losing control of emotions; (C) *External Catastrophes*: e.g., elevators collapsing, victimized by criminals, airplane crashes, earthquakes.

9. Enmeshment / Undeveloped Self

Excessive emotional involvement and closeness with one or more significant others (usually parents or partners), at the expense of full individuation or normal social development. Often involves the feeling thatone or both of the enmeshed individuals will not survive or have a reason for living without the constant involvement of the other.

In some individuals, there is a strong desire to escape the enmeshment, and a negative view of significant others as smothering, intrusive, lacking healthy boundaries, or refusing to accept that their child or partnerhas different needs or desires. Enmeshed individuals often lack a distinct and

separate identity, and often report feeling empty, of floundering, and having no direction in life.

10. Failure

The belief that one has failed, will inevitably fail, or is fundamentally inadequate relative to one's peers, inareas of *achievement* (school, career, sports, etc.). Often involves the belief that one is stupid, inept, untalented, ignorant, lower in status, less successful than others, a loser, etc. Can be distinguished from Defectiveness because insecurity is primarily focused on achievement and success, rather than on social inadequacies, or a core sense of being unacceptable and unlovable.

11. Subjugation / Invalidation

Excessive surrendering of control to others because one feels coerced and is unrealistically afraid of the negative consequences of asserting one's rights and expressing feelings (such as anger, criticism, retaliation,or abandonment by the subjugator). Usually involves the perception that one's own desires, opinions, and feelings are not valid or important to others. The two major forms of subjugation are:

a. ***Subjugation of Needs***: Suppression of one's legitimate preferences, rights, needs, and desires.
b. ***Invalidation of Emotions***: Suppression of one's emotions, because of the expectation that one's feelings will be discounted, ignored, criticized, or not taken seriously by others; or that there willsome kind of punishment or rejection by others for expressing emotions.

Frequently presents as excessive compliance, combined with hypersensitivity to feeling trapped or controlled. Often leads to a build-up of anger, manifested in maladaptive symptoms (e.g., passive-aggressivebehavior, uncontrolled outbursts of temper, psychosomatic symptoms, withdrawal of affection, "acting out",or substance abuse).

Impaired Limits

12. Entitlement / Grandiosity

The feeling that one is superior to other people; entitled to special rights and privileges; or not bound by the rules of reciprocity that guide normal social interactions. Often involves an insistence that one should be ableto do or have whatever one wants, regardless of what is realistic, what others consider reasonable and socially acceptable, or the harm done to others. Frequently characterized by an exaggerated focus on superiority (e.g., being among the most successful, famous, wealthy) -- usually to achieve power, control, attention, or admiration. Sometimes includes excessive competitiveness with, and envy of, others. Entitled individuals often dominate and control the behavior of others in line with their own desires -- without apparent empathy or concern for others' needs or feelings.

13. Insufficient Self-Control / Self-Discipline

Pervasive inability or refusal to exercise sufficient self-control, self-discipline, and frustration tolerance toachieve one's personal goals, or to restrain the inappropriate expression of one's emotions and immediate desires. These individuals are often impulsive and have difficulty postponing immediate gratification. Theymay also "lose control' of their emotions and express them inappropriately. Sometimes includes difficulty staying focused on one task, especially if it is boring or unpleasant, regardless of the long-term benefits. (This schema does not usually include addictive or compulsive behaviors, unless they are accompanied bypervasive difficulty with self-discipline across a broad range of situations.)

Excessive Responsibility & Standards

14. Self-Sacrifice

Excessive focus on *voluntarily* meeting the needs of others in daily situations, at the expense of one's owngratification. The most common reasons are to prevent causing pain to others; to avoid guilt from feelingselfish; or to maintain the connection with others perceived as needy. Often results from high standards related to overresponsibility to others, regardless of the cost to oneself. Often results from an acute sensitivity to the pain of others, or from an implicit belief that taking care of others is morally or ethically more important than self-care. Sometimes leads to a sense that one's own needs are not being adequately met, and to resentment of those who are being taken care of.

15. Unrelenting Standards / Hypercriticalness

The underlying belief that one must strive to meet very high *internalized standards* of behavior and performance, usually to avoid criticism or shame. Typically results in feelings of pressure; difficulty slowingdown; and in hypercriticalness toward oneself and others. To be considered a maladaptive schema, the individual must demonstrate significant impairment in: pleasure, relaxation, health, self-esteem, sense of accomplishment, performance, sense of well-being, or satisfying relationships.

Unrelenting Standards typically presents with: (a) ***perfectionism*****,** inordinate attention to detail, or an underestimate of how good one's own performance is relative to the norm; (b) ***rigid rules*** and "shoulds" in many areas of life, such as unrealistically high moral, ethical, cultural, or religious principles; or (c) preoccupation with ***time and efficiency***, so that more can be accomplished; or (d) a sense of being ***driven toaccomplish*** and achieve at a very high level, often across many areas of life.

Unclassified Schemas

16. Approval-Seeking / Recognition-Seeking

Excessive emphasis on gaining approval, recognition, or attention from other people, or fitting in, at the expense of developing a secure and true sense of self. One's sense of esteem is dependent primarily on the reactions of others rather than on one's own natural inclinations. Sometimes includes an overemphasis on status, appearance, social acceptance, money, or achievement -- in order to gain *approval, admiration,* or *attention* (not primarily for power or control). Often includes high awareness of what others will approve of,and a willingness to change oneself accordingly. Frequently results in major life decisions that are inauthentic or unsatisfying; or in hypersensitivity to rejection.

17. Negativity / Pessimism

A pervasive, lifelong focus on the negative aspects of life (pain, death, loss, disappointment, conflict, guilt, resentment, unsolved problems, potential mistakes, betrayal, things that could go wrong, etc.), while minimizing or neglecting the positive or optimistic aspects. Usually involves an exaggerated expectation -- ina wide range of work, financial, or interpersonal situations -- that things will eventually go seriously wrong,or that aspects of one's life that seem to be going well will ultimately fall apart. Usually involves an inordinate fear of making mistakes that might lead to: financial collapse, loss, humiliation, or being trapped in a bad situation. Because potential negative outcomes are exaggerated ("catastrophizing"), these patients are frequently characterized by chronic worry, anxiety, vigilance, complaining, or indecision.

18. Punitiveness

The belief that one should be harshly punished for making mistakes. Involves the tendency to be angry, intolerant, punitive, and impatient with those people (especially oneself) who do not meet high expectationsor standards. Usually includes difficulty forgiving mistakes in oneself or others, because of a reluctance to consider extenuating circumstances, allow for human imperfection, or empathize with feelings. Individuals typically demonstrate a tone of voice or behavior that is degrading, contemptuous, or demeaning toward theperson deemed to be deserving of punishment, including themselves. (Self-punishment is probably the mostcommon form of this schema, especially in mental health settings.)

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