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Shema-usmerjen pristop v kognitivno-vedenjski psihoterapiji

Ključne besede: self, kognitivno-vedenjska terapija, shema terapija, posttraumatska stresna motnja

Povzetek: Shema-usmerjen pristop v kognitivno vedenjski psihoterapiji pomeni razvijanje dinamičnega in sočutnega odnosa psihoterapevta do klienta. Namen pristopa je pomagati klientu doseči in ohranjati najboljše psihofizično delovanje in zdravje. Sočuten pristop, kot avtentično človeško dejanje, terapevt izraža skozi kvalitete sočutja, kompetentnosti, vestnega ravnanja, zaupanja in zavezanosti. V shema-usmerjenem pristopu v kognitivno vedenjski psihoterapiji je poudarek na kogniciji, afektu in vedenju z namenom, da se ponovno ojačajo in povečajo viri, s pomočjo katerih se osebnost klienta v psihoterapiji redefinira. Model shema psihoterapije predpostavlja, da se sheme razvijejo kot rezultat napačne vzgoje ali nezadovoljenih ključnih čustvenih potreb v otroštvu. V njem je osemnajst močnih in škodljivih shem, ki jih razvrstimo v pet shem oz. področij: prekinitev in zavrnitev, motnje avtonomije in delovanja, motnje meja, usmerjenost v drugega in pretirana čuječnost ter zavrtost. Ob grožnji razvije osebnost tri možne neprilagojene stile vedenja: prekomerno kompenzacijo, izogibanje in predajo. Shema terapija ima tri faze: intervju, edukacijo in spremembo. Cilj shema usmerjenega pristopa v kognitivno-vedenjski psihoterapiji je preusmeriti klientov samodestruktivni proces tako, da sam prepozna zgodnje neprilagojene sheme in jih popravi ter s tem prepreči nadaljnja izkrivljanja in / ali fragmentacijo.

Schema-Focused Approach to Cognitive Behavioral Psychotherapy

Key words: self, cognitive-behavioral therapy, schema therapy, post-traumatic stress disorder

Abstract: I define schema-focused approach to cognitive behavioral psychotherapy practice as a dynamic, caring, helping relationship in which a psychotherapist assists the client in achieving and maintaining optimal functioning and health. Caring, an authentic human action is expressed through attributes of compassion, competence, conscience, confidence, and commitment. The schema-focused approach to cognitive behavioral psychotherapy focuses on cognition, affect, and behavior in an attempt to increase the resources upon which the self draws in the process of redefining itself in psychotherapy. The schema psychotherapy model postulates that schemas develop as a result of toxic upbringing or unmet core emotional needs in childhood. In this model, 18 possible damaging and powerful schemas grouped into five schema domains (Disconnection and Rejection, Impaired Autonomy and Performance, Impaired Limits, Other-Directedness, and Overvigilance and Inhibition) emerge. In response to a threat the self develops three possible maladaptive schema coping styles of surrender, avoidance, and overcompensation. The schema therapy has three phases: the Assessment, the Education, and the Change. The goal of schema-focused approach to cognitive behavioral psychotherapy is to reverse the client's self-destructive process by enabling the individual to recognize the early maladaptive schemas and to correct them, preventing further distortions and/or fragmentation.

Psychotherapy with the Reference to Self

Psychotherapy, as a human science, is concerned with the experience of human beings in relation to health and illness. Human experience is shaped by history, relationships, politics, social structure, gender and culture. Psychotherapists are concerned with how these perspectives shape the actions and reactions of human beings. Psychotherapy seeks to maximize the clients' strengths, assets and potentials, as well as contribute to their quality of life.

Psychological literature is saturated with references to *the self*. A random sampling of some recent titles relative to "self", includes Vittorio Guidano (1991) *The Self in the Process*; Steven and Sybil Wolin (1993) *The Resilient Self*; John King-Farlow and Sean O'Connell (1988) *Self-Conflict and Self Healing*; Roy Baumister (1991) *Escaping the Self*; Rebecca Curtis (1991) *The Relational Self*; and Gerrit Glas (2006) *Person, personality, self and identity: A philosophically informed conceptual analysis*.

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What Constitutes Self? The term “self” has been defined in various ways. Hall and Lindzey (1957) delineate self as a “process” which controls behaviour and adjustment, including such mental activities as thinking, remembering and perceiving. Epstein (1990) posits that each person possesses assumptive constructs about the self and the world. He hypothesizes that each person structures a personal theory of reality (composed of a self theory and a world theory) which serves four basic functions: (a) maintenance of balance between pleasure and pain; (b) assimilation of new information (reality); (c) preservation of positive self-esteem; and (d) support of relatedness (the need to be in contact with others).

Epstein (1990) further defines three fundamental beliefs that make up a personal theory of reality as: (a) the world is kind and source of happiness, (b) the world is meaningful and controllable, and (c) the self is worthy. Janoff-Bulman’s (1985) three basic assumptions about the self and the world are congruent with Epstein (1990) hypothesis. Janoff-Bulman’s (1985) supposition is that (a) the self is vulnerable, (b) the world is comprehensible and meaningful, and (c) the self is viewed positively.

Rogers (1951) argues that human behaviour is governed primarily by each individual’s sense of self, or “self-concept”—which animals lack. Both, he and Maslow (1954), maintain that to fully understand people’s behaviour, psychotherapist must take into account the fundamental human drive toward personal growth. They assert that people have a basic need to continue to evolve as human beings and to fulfil their potentials. The self also mediates the individual’s interaction with the environment. Meaning is a function of how a person construes the environment as a result of interaction with surroundings (Blumer, 1969). It is the very system of cognitive-affective make-up about personal self that determines and creates the meaning of the individual’s experience (Markus & Nurius, 1986).

Self can also be defined as the composite of beliefs and feelings an individual holds about oneself at a given time. These beliefs and feelings are primarily formed from our perceptions and our interpretation of others’ reactions. They direct our behaviour (Drieveer, 1976). However, Glas (2006) professes that self cannot be reduced or identified as a set of functions, capacities or mental states since self will remain to exist as a mystery.

I believe the perception of self—what we think of as ‘I’, ‘me’, or ‘myself’—is a vital part of the human experience. No construct, at least at the theoretical level, is so integral to the human being as the “self-concept”. Thoughts may be reorganized and acted upon by further thought in much the same ways as our experience is modified by new inputs from the physical or social environments.

Theoretical Orientation

Cognitive Model of Processing Information: Schema. My theoretical position is that behavior is caused by both biological and social factors; and personality and adjustment are based on interaction between both biological and environmental factors (Gentry & Kobasa, 1984). In any given situation, how an individual discriminates between relevant and irrelevant information is based on and dictated by rules. These rules, situation-specific patterns of information-processing, are called schemas. What is of interest is not the cognition but the more elusive meaning that we assign to a given event.

This information-processing model, that I espouse, has been popular in experimental cognitive psychology for some years. In making a shift from an early associationistic supposition to a more constructivistic perspective, the concept of schema emerged. It postulates that several unconscious cognitive processes operate on both incoming and stored information. I assert that this concept of schema is important in the cognitive model because it explains the mechanism of distorted perceptions (cognitive errors) that leads to psychopathology. As individuals interact with their environment, distortions may occur through selective attention, inappropriate classifi-

cation of events, idiosyncratic storage of information, and/or inaccurate retrieval from memory.

Thoughts may be reshaped and reorganized and acted upon by further thought in much the same ways as our experience is modified by new inputs from the physical or social environments. "There is constant restructuring of material; memory is never simply a process of passive storage" (Singer, 1987, p.108). Cognitive theories also assume that some attitudes, beliefs, or patterns of information are more central or self-oriented than others and, therefore, are more likely to evoke complex affective responses. Our ways of knowing the world are intrinsically bound up with our ways of feeling (Rychlak, 1981; Zajonc, 1980).

There are varying definitions of a schema I regard as important. (1) Segal (1988) defines schema as an organized cluster of knowledge, composed of the elements of past reactions and experience (about a particular object or sequence of events) guiding subsequent perception and evaluation. (2) Markus (1977) explains self-schemata as "cognitive generalization about the self, derived from past experience that organizes and guides the processing of self-related information in the individual's social experiences" (p. 63). (3) Young (1990) describes schema as "an extremely stable and enduring pattern of thinking developed during childhood ... important beliefs about oneself and the environment which the individual accepts without question" (p. 70).

I particularly embrace Young's (1990) interpretation of schemas as themes, learned at a very young age, which operate to interpret new information in ways that are congruent with the experiences. With the passage of time, schemas are reinforced. Life events trigger the schema that activates automatic thoughts leading to emotional and behavioral discharge (Epstein, 1990). Schemas, information processing skills, are then templates that organize and structure our reality (Lassen, 1992; Lassen & Elliott, 1993).—In summary, I define a schema as a cognitive representation of one's experiences, which serves an individual in continually constructing his or her current perception of events.

Pathology. Our schema may be adaptive or maladaptive. The maladaptive schema is shaped by systematic cognitive distortion, as the content of automatic thought stems from an underlying schema (Collard, 2004). Errors in cognition distort data from the intrinsic or extrinsic world, which further modify the individual's perception of reality. These early maladaptive schemas of emotional disturbances are characterized by an individual's unconditioned belief about him/herself in relation to the environment and are influenced by the cognitive distortions (negative interpretations and predictions) of every day events (Young, 1990).—In summary, the maladaptive schemas are self-perpetuating, dysfunctional, activated by the environment, tied to a high level of affect, and are influenced by early experiences. Maladaptive behaviors develop as a response to dysfunctional schemas.

Young, Klosko and Weishaar (2003) categorize maladaptive schemas in terms of Disconnection and Rejection, Impaired Autonomy and Performance, Impaired Limits, Other-Directedness, and Overvigilance and Inhibition domains. These schemas function by three maladaptive coping styles/survival processes: surrender, avoidance, and overcompensation, that exert powerful influence on our behavior to insure their existence.

At the cognitive level an individual fosters the process of *schema surrender* through cognitive filtering (information is accepted as true) and self-defeating behaviors (which perpetuate the schema by acceptance, compliance and passivity).

An individual develops *schema avoidance*, an automatic process for avoiding either the triggering of the schema, or the experience of affect connected with the schema. An individual may experience cognitive avoidance (the automatic attempt to block thoughts that might trigger the schema), affective avoidance (blocking feelings that might unleash schema), and behavioral avoidance (avoidance of real-life situations that might evoke schema). These processes of emotional/affective or cognitive avoidance can be automatic or voluntary but are evoked to prevent thinking about disturbing event or feeling extremely painful emotion. This process can also be

described as aversive conditioning (Young, 1990).

An individual exhibits schema *overcompensation* when adopting a cognitive and behavioral style opposite to that which is expected, in an attempt to have his/her needs met and/or to challenge his/her schemas (Young, 1990). Overcompensation develops as means of escape from the sense of helplessness and vulnerability and serves to help individual cope with core feelings of emotional deprivation and defectiveness (Young, et.al, 2003).

Schema Approach to Psychotherapeutic Change Process. Young's (1990) psychotherapeutic approach endeavors to assist people to overcome emotional problems by correcting distorted conceptualizations and dysfunctional beliefs underlying these cognitions which direct behavior. Schema therapy incorporates cognitive-behavioral therapy, Gestalt therapy, attachment theory and object relations (Young, 2005).

Cognitive-behavioral psychotherapy (Schema-focused approach) is my psychotherapy of choice because I accept its suppositions that affect and behavior are primarily determined by the way we structure our world.

The psychotherapy consists of changing negative interpretations and negative predictions; in other words, it consists of changing maladaptive schemas. A psychotherapist helps a client restructure his/her thinking by weakening the Early Maladaptive Schemas, which prevent rebuilding client's healthy self. Over time moment to moment the therapy proceeds through not mutually exclusive stages of (a) bonding and emotional regulations, (b) schema mode change, and (c) individuation (Young, 2005).

The steps in therapeutic process:

1. An alliance is formed between the therapist and the healthy self of the client against the maladaptive schema. The therapist bonds and establishes trust with the client.
2. Comprehensive assessment is conducted to identify which schemas are most important in client's psychological make-up. A therapist, while conducting an assessment and obtaining information regarding recent events, is alert, while discussing client's life history, for patterns/themes related to schema
3. Client is educated about schemas with the help of a Schema Questionnaire. The Schema Questionnaire is assigned to the client as homework assignment during the second session. This questionnaire serves as a guide to identify client specific maladaptive schema within affective domain, cognitive realm, and behavioral functioning. It also proves as a useful tool to direct the process of therapy.
4. Schemas are elicited in a number of ways during the sessions. To assess how schema are played out Lassen and Elliott (1993) suggest reviewing life/developmental history to attain memories (i.e., "father ignored me", for example, denotes abandonment schema); resorting to imagery (i.e., "close your eyes and tell me the first image from your childhood that comes to your mind") and analyzing dreams which tend to validate the early maladaptive schemas.
5. Schema surrender behavior, schema avoidance behavior, and schema overcompensation behaviors are identified and confronted.
6. Primary, secondary, and associated schemas are distinguished.
7. The core schemas are targeted for the change process. The client is assisted to transfer the work in session to outside living.
8. In the final stage of individualization the client develops a secure sense of self and is empowered to live a healthy and satisfying life.

Psychotherapist's Interventions. The four categories of techniques, to be used to weaken client's schemas, are: emotive, interpersonal, cognitive, and behavioral. *Emotive Technique* encourages a client to express the emotional content of the dysfunctional schema (the more often the feeling is expressed, the greater the distance from the schema). *Interpersonal Techniques* are those where schemas through client's interaction with others can be exposed. A therapist-client

dyad serves this purpose. *Cognitive Techniques* highlight and challenge the schema-cognitive distortions. *Behavioral Techniques* encourage the client to change behavioral patterns so that schema maladaptive behaviors are reduced and healthy coping responses are strengthened.

Psychotherapeutic Change Outcome: The Assimilation Model. My conceptualization of evaluating the process of psychotherapeutic change draws on the works of Piaget (1969), Rogers (1951), and Stiles, Barkham, Shapiro, and Firth-Cozens (1992). The assimilation model purports a systematic sequence of changes in the client's cognitive structure, a schema, that occur during the therapist-client interactions. Stiles et al. (1992) refer to the assimilation continuum whereby a client gradually assimilates a problematic experience into its system of associations through predictable stages. During these stages a schema is being warded off, is entering awareness as unwanted thoughts, is becoming clarified as a problem, is attaining understanding and insight, is contributing to adaptive changes, and finally it is being mastered and integrated into everyday life. In other words, the stages of assimilation are: warded off, unwanted thoughts, vague awareness, problem statement/clarification, understanding/insight, application/working through, problem solution, and mastery. Furthermore, Stiles et al. (1992) specify that in assimilating an experience, the encounter also passes through the sequence and spectrum of affective reactions from acute pain to joyful mastery.

Beck, Rush, Shaw, and Emery (1979) and Horowitz (1991) incorporate the role of unconscious experience under the term "schema" in the cognitive-behavioral approach to psychotherapy. Their postulates blend with my premise that from the endless bounds of external influences and the depths of the inner world emerge crucial aspects of the self. Toukmanian (1990) schema-based information processing concept model on client change specifies that how clients express themselves during the psychotherapy reveals that all clients share common perceptual processing characteristics despite of their many differences. Consequently, the dynamic activities of human mind suggest that the self is not merely the center and the circumference of the psyche, but is also a process—the process of integrating and synthesizing disparate, unconscious elements into conscious and unconscious entities.

In order to illustrate the process of identifying and changing schemas, I will present a client case study.

Psychotherapeutic Assessment

Name: Wayne Wood (Alias)

Date of Birth: May 06, 1962

Sex: Male

Date of Evaluation: June 2, 9, 16, 23, 2007

Date of Report: June 30, 2007

Marital Status: Married

Occupation: Pilot (Captain)

Referral Source: B. Rob, MD (Alias)

Suicide Risk: Yes

Source and Reason for Referral: Captain Wood was referred for therapy by Bill Rob, his family medical doctor, who reported that Captain Wood has been suffering from mood disorder.

Psycho-social History

1. *History of Present Problems.* Captain Wood reports that he was well and able to function in his profession as a pilot of mid size and heavy jets until the spring of 2005. At that time he was appointed as Director of Safety for Nation Air. On July 11, 2005 there was a major crash in Saudi Arabia of Nation Air with 200 dead people. Within twenty four hours, Captain Wood was on the scene helping to find the cause of the accident which was caused by a mechanical failure (the airline used "cheap" worn-out tires). He was profoundly shaken by that experience. Some three weeks later on the plane home he found himself to be fearfully anxious and he was weeping on this flight home as a passenger. Soon afterwards he flew again as pilot but he found himself progressively more and more fearful of flying. He did poorly on check rides and by November

of that year he did poorly in a simulator ride. In the fall of 2006, one year later, he could not pass new training on the 757. Captain Wood explains that he had a number of significant psychological symptoms at that time. He was experiencing vivid and intense recall of events from the crash, such as, sifting through the rubble of the plane (that he had known and flown) and finding dead bodies and parts of people. Since then he has had nightmares and intrusive memories of these events; he has violent emotional reactions, particularly to sense of smells, such as smelling a barbecue, which recalls the event of burning bodies.

As Captain Wood was experiencing psychological symptoms he was involved with in unpleasant political arguments with his superiors over the causes and sequel of the crash. After the accident he was debriefed by Dr. Muffet (alias) who helped him understand what he was experiencing. However, Captain Wood, who has always prided himself on being supremely in control of himself, could not believe that his feelings were not under control; nor could he comprehend that he did not have as much political power as he had thought. He attempted to place blame where blame was due (Nation Air) but found himself in the midst of the massive cover-up by the airline and he was made to be a scape-goat. This resulted in being “black balled” leading to Captain Wood experiencing one rejection after another.

2. *Psychological and Psychiatric History.* Prior to the airplane crash in 2005 Captain Wood denies any previous experience of depressive disorder nor is there any family history of such illness.

3. *Family History.* Captain Wood was born in Edmonton, the only son of his biological father and mother. His father died when he was about six month old. Within a year his mother remarried and gave birth to two sons. Her second husband was an RCMP flying officer who soon moved to Air Canada where he became a captain. He retired after thirty years of service with that company. Though Captain Wood states that his childhood was very good, he describes his father as very strong, distant, insensitive, emotionally absent, as pilots often are. Captain Wood idealized him and strove to meet his father’s demands to be “the very best.” He feels his efforts paid off because every now and then his father would acknowledge his accomplishments and would say that he was pleased. By contrast, Captain Wood was very close to his mother and two younger siblings. The only major jolt in his life surfaced at age twelve when he was told of his biological father’s death and the fact he was his father’s never adopted stepchild.

4. *Personal/Developmental History:*

- a) *Prenatal and birth occurrences:* Uneventful.
- b) *Physical and medical problems/injuries:* None.
- c) *Developmental milestones:* Unremarkable.
- d) *Emotional difficulties in childhood:* No enuresis, temper tantrums, or nightmares.
- e) *School experience:* Captain Wood did well in school and was very good in sports. In fact, he had even contemplated to register for a degree in a Physical Education at university. However, he enjoyed flying more and through an Air Cadet scholarship obtained his pilot’s license (again, in an attempt to show his father that he is worthy of his love and recognition).
- f) *Social development and adjustment (including legal matters):* Normal.
- g) *Ethnic and/or religious influence:* None.
- h) *Sexual experience:* Currently experiences low sexual drive.
- i) *Occupational history:* Captain Wood started in ground crew at Air Canada when he was in his 20’s. After eighteen years of service with Air Canada, he had left airline to join Wardair where he achieved on-going promotions, including captaincy. However, in one year Wardair went bankrupt, which, Captain Wood states: “Effectively pulled the rug out from under my feet.” For the first time Captain Wood began to feel insecure about his career and his position. From the defunct Wardair, Captain Wood went to Nation Air in 1991 where he achieved rapid promotions as well. From Line Pilot he was promoted to Check Pilot and than to Chief of Safety, the position

he achieved just before the Saudi Arabia crash. For past two years he has helped his wife manage doughnut shop.

j) *Marital status and adjustment*: Captain Wood states that he has always had good relations with women. He stated, "I was always very sure of myself." He married at age eighteen. This marriage lasted only six months and it was followed by a five year common-law relationship. Currently he is in a marriage which has lasted for the past twelve years. There are two sons from this marriage and one step daughter from his wife's first marriage.

Mental Status

5. *Appearance*. Captain Wood appears as a tall, distinguished looking man. He presents himself as an unhappy, prematurely old man of forty two with gray hair, a pale face, and a worried expression. He looks depressed and sad.

6. *Personality*. Captain Wood exhibits cooperative, sensitive, and respectful personality pattern. He is oriented to time, place, and name. There is no disorder of thought form or content (i.e., no hallucinations, delusions, looseness of association).

7. *Behavioral Functioning*. He feels overly alert, jumpy, 'like a firecracker'. He appears tense. He had lost 40 lbs immediately after the plane crash accident. He startles easily. He has a good approach to testing. His speech is fluid, fluent, emotional, slow and careful. As the interview progressed, he became progressively more animated and leaned forward in his chair, his speech became quicker and his face brighter. He even smiled occasionally. He described vegetative signs of depression.

8. *Intellectual and Cognitive Functioning*. Captain Wood is preoccupied with being "let down". He states he can trust no one although he communicates openly and answers all the questions freely. He describes poor concentration, avoidance of people and sense of a loss of control over his inability to function more effectively. Particularly, loss of control is a very threatening and distressing feeling for him. Intelligence is above average. His judgment and insight are within acceptable limits.

9. *Affective Expression*. Captain Wood feels ashamed, unhappy, and overall, sad. He describes himself being labile with his emotions up and down and feeling at times sudden intense anger.

10. *Self-Perception*: He experiences himself as weak, unappreciated, having no confidence.

11. *Interpersonal Conduct*: Captain Wood is polite, frank and cooperative.

12. *Assessment Instruments and Evaluative Procedures*: Clinical Interview, Mental Status Evaluation, MMPI-2, Young Schema-Questionnaire, and Mood Disorders Assessment Tool (Beck Depression Inventory).

The results of MMPI-2 are valid. They show a high degree of turmoil and confusion. The test indicates that he is telling the truth. He has an unusually low K score of 30. This score is characteristic of people who tend to be very critical of themselves and others and who are self-dissatisfied, ineffectual, socially conforming and relatively compliant to authority. He is clearly not malingering.

The personality scales show a clear 1, 8 score. This indicates anxiety, depression and overall inhibition. Typically such people report cynical outlook toward life, agitation, tenseness, and jumpiness as well as inability to concentrate and confused thinking. They tend to be inefficient carrying out responsibilities. They often present themselves with physical illness and somatic complaints while they resist psychological interpretations of problems. These people greatly fear loss of control, tend to express themselves directly, they can be irritable and resentful when threatened, they tend to be oversensitive and rather suspicious of others motivations and actions they tend to be rather distant interpersonally because they feel vulnerable.

Clinical interview combined with psychodiagnostic tests provided enough information to rule out Narcissistic Personality traits, Malingering, and Anxiety Disorder (elevated Scales Hs

and Pa scores on MMPI-2). Beck Depression Inventory: Score of 45 is indicative of severe depressive mood. Schema Questionnaire: High scores on lack of individuation, unlovability, loss, emotional deprivation, failure, and unrelenting standards. The findings reflected on psychodiagnostic testing certainly bear out and reinforce the functional evaluation (clinical finding) of Captain Wood during the clinical interview.

14. *Formulation (DSM IV):*

Axis I: Post Traumatic Stress Disorder (chronic), Code No: 309.81 (Rule out Anxiety Disorders and Malingering)

Axis II: No diagnosis, narcissistic personality features, Code No: V71.09

Axis III: None

Axis IV: Psychosocial and Environmental Problems: Occupational, (plane crash; sex difficulties, arguments with spouse, change of residence, working in a dough-nut shop)

Axis V: Global Assessment of Functioning, Current: 50, highest level in past year: 50, (erious impairment in occupational functioning – unable to fly as a pilot)

15. *Impressions.* Captain Wood is suffering a very significant post traumatic stress disorder precipitated directly by the conditions of his workplace, specifically the crash of a jet for whose safety he was held responsible in 2005. In addition, Captain Wood also exhibits significant depressive symptoms (as evidenced by his weight loss, loss of libido, inability to concentrate, loss of hope and suicidal ideation, that he did volunteer, which reflects a significant depressive episode). The main reason for his loss of hope is that he has a tremendous fear of flying and flying is the center of his personal universe. As a result, he is totally incapable of pursuing his career as pilot.

16. *Summary and Recommendations.* There is no doubt that Captain Wood is still suffering from a significant post traumatic stress disorder precipitated by his involvement in the accident at Jeddah. He has symptoms evolving around relieving the event. In addition, he experiences increased arousal and alienation. These three classes of symptoms (re-experience, avoidance, and increased arousal) meet diagnostic criteria for PTSD. Furthermore, because of the plane crash, he feels isolated, alienated from his wife, his children, and his peers. As a result he is incapable of pursuing his career as a pilot. All the failures and rejections during his flying career further fuel the post traumatic stress disorder.

17. *Treatment Management Plan:*

a) *Goals treatment/management:*

(i) Resolve post-traumatic stress disorder (assimilate the experience into personal theory of reality)

(ii) Restore his belief that he is worthy human being (alter the sense of helplessness and improve level of self esteem);

(iii) Improve relatedness and relationships with others;

(iv) Restore his sense of confidence into his competence;

(v) Alter his unreasonable expectations of self; and

(vi) Provide hope that life can be meaningful.

b) *Methods of intervention:* Schema-Focused Approach (Cognitive Behavioral Therapy).

c) *Anticipated length of treatment/management:* 30 Sessions

An Illustrative Example of Schema Driven Behaviors and Interventions

Therapy Goal for July 14, 2007

1. Change negative interpretations (not loved by his step-daughter) and negative predictions (I am a failure unless she loves me) of the schema driven behavioral processes.

Early schema to be altered: Domain: Disconnection and Rejection

Primary Schema: Emotional Deprivation experienced from his step-father and now main-

tained by his step-daughter, Leslie-Anne.

Associated Schema: (1) Abandonment/Loss, (2) Social isolation/Alienation, (3) Unrelenting Standards

2. Strengthen adaptive behaviors (will have a mutual relationship with his step-daughter, with equal give and take).

A. Supporting Evidence. Throughout his life, Wayne felt that he could never obtain his father's love, affection, and recognition. He states: "Praise was earned and reluctantly given."

B. Presumed Origin of Schema. Wayne's father died when he was 6 months old. He was never adopted by his step-father. Wayne was not told until age 12 that his "father" was not his biological father, who Wayne idolized.

C. Schema-Driven Behavioral Process

(1) Schema Surrender. Wayne pursues his step-daughter, Leslie-Ann who is not emotionally available to him (or to any other person). Therefore "rejection" and the feeling of abandonment by his step-daughter are constant.

(2) Schema Overcompensation Behavior. Wayne demands that Leslie-Ann gives him attention. He continuously follows her, sits next to her, or sleeps on the floor of her room (in order to be close to her) or asks her questions when she is quiet.

(3) Schema Avoidance Behavior. Wayne avoids intimacy with his wife. He has many arguments with her which make her emotionally withdraw from him.

D. Schemas Interactions. The more Wayne pursues Leslie-Anne (abandonment/loss schema), the less his needs for connectedness with her are met, and the more he feels alienated from her (social isolation schema).

E. Schema Change Strategies:

(1) Emotive Techniques

- Continue to express painful experiences/emotions to the psychotherapist.
- Have imaginary dialogue with father.

(2) Interpersonal Techniques

- Continue with supportive alliance between the therapist and Wayne.
- Be kinder to the wife (do not start a fight) so that the daughter would not feel she has to protect the mother.

(3) Behavioral Techniques

- Walk away from triangle (daughter-father-mother where daughter acts like a Rescuer, wife like a Victim and Wayne ends up being Persecutor).
- Do not ask a question of Leslie-Ann when Wayne knows that she is not interested in talking.
- Do not follow Leslie-Ann around.
- Do not go into her room unless asked.

(4) Cognitive Techniques

- Continue to identify dysfunctional thoughts and consider evidence for and against them. Confront and challenge schema-driven conduct by verbalizing the evidence against the schema.
- Begin to let go of the father's influence by being accepting of him as a person with human frailties.
- Begin to accept that his father was not capable of being there for him.

Progress Notes and Termination (December 23, 2007). Wayne attended 27 sessions. On December 23, 2007 Rotter Incomplete Sentence Blank - Adult Form was (RISB) administered. The RISB results indicate Captain Wood's complete assimilation of early maladaptive schemas. The problematic feeling of failure and self blame for the plane accident had been fully assimilated.

Early Maladaptive Schema (i.e., others failed him, in particular his father) were synthesized and incorporated into emotional and behavioral change. Captain Wood was able to specify that “My father was a good man with many weaknesses” (RISB item 35). Captain Wood is once again pursuing flying career. – Close file if no contact in 3 months.

Discussion

I identify with cognitive-behavioral schema focused therapy because it offers an integrative approach for treating challenging and treatment resistant patients. Schema focused treatment approach focuses on cognition, affect, or behavior in an attempt to increase the resources upon which the self draws in the process of redefining itself in therapy. The goal is to reverse the client’s self-destructive process by enabling the individual to recognize the early maladaptive schemas and to correct them, preventing further distortions and/or fragmentation.

Much research has been conducted on effectiveness of schema-focused cognitive psychotherapy. Stiles et al. (1992) report success with individuals seeking psychotherapy at different phases of their problem formulation, insight, or application requiring systematic sequence of schema therapeutic techniques applications. Forster (1996) notes successful treatment using schema approach to treatment. This is in accordance with other case studies reporting the effectiveness of considering schemas therapy.

In summary, my philosophy of psychotherapy, as a helping profession is that any speculation about how the “mind” works must be in accordance with the observable behavior of people in their natural/cultural settings. In a broad sense, my helping theories (cognitive-behavioral psychotherapy – Schema Focused Approach) emphasize coping techniques, individual’s adaptation to personal renewal or critical life experiences (or chronic illness), and self-responsibility in recovery process or promotion of wellness. My goal is to assist individuals in (a) expanding their awareness to effectively deal with issues that obstructs their current functioning, (b) regaining control over their life situations, and (c) resolving pain and suffering which keeps them from experiencing life and moving toward growth and enhancement. □

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