The heart of Young and colleagues' treatment model is that need satisfaction during childhood leads to the development of healthy schemas and related functional affective and behavioural patterns, while early need frustration leads directly to the development of EMS and related negative patterns of behaviour and maladaptive coping. The emphasis on early childhood development and the explicit causal role of unmet core emotional needs in producing EMS distinguished schema therapy from the prevailing theories of cognitive therapy at the time. Especially relevant types of early life experience were thought to be one or more of the following: (a) toxic frustration of needs; (b) exposure to overt trauma or victimisation; (c) a lack of boundaries or limits ('too much of a good thing'); and (d) selective internalisation or identification with significant others [2].

The Influence of Attachment Theory in Schema Therapy

Since their beginnings in the 1960s, theories of attachment [3] were quick to influence the hearts and minds of therapists in the field. The parallels between the experiences of clients' early patterns of attachment and their present-day problems appeared obvious. However, practical applications of this powerful new theory were lacking. Young was quick to recognise the importance of the theory for his emerging schema therapy model, integrating its emphasis on secure attachment as a core emotional need. Young acknowledged that the most important need for the developing child was the need for safe, stable, nurturing, and validating attachments. For Young, attachment to others was not a preference but a core emotional need, required for healthy development and well-being. To the degree that this need was thwarted during development, EMS would ensue. As noted earlier, children have a range of needs but, according to Young, attachment needs are of primary importance, laying the groundwork for other needs to be satisfied. The need for attachment and its relationship to a set of schemas in the Disconnection and Rejection domain is a primary focus for schema therapy interventions, especially *limited reparenting* interventions (see Chapter 6: Intervention Strategies for Schema Healing 1: Limited Reparenting for more detail). The original set of eighteen EMS – organised by their original domains and described in core belief terms – is described in Table 1.1.

Young's Schema Concept

Expanding upon earlier conceptions of schemas from authors such as Piaget [7], Young and colleagues [2] conceptualised schemas as a normal and central human phenomenon: an organising principle that enables humans to interpret and make sense of their experiences and the world. As children navigate and interpret the world, they will generally develop functional scripts, or schemas, which are representations of the world that are activated according to situational demands. Many schemas are mundane, representing what to expect (expectancies) or the kind of rules likely to be operating in one's environment, based on past experiences. In the broad field of cognitive psychology, schemas can be positive or negative, adaptive or maladaptive, and can be formed during childhood or later in life. Young's EMS refer to a core set of *problematic* schemas that tend to develop during childhood or adolescence, and which are centrally implicated in the development of various forms of psychopathology. For Young and colleagues [2], EMS can be defined as:

- a broad, pervasive theme or pattern
- comprised of memories, emotions, cognitions, and bodily sensations

Table 1.1 Schema domains and corresponding early maladaptive schemas*

Disconnection and Rejection Domain

1. ***Abandonment/Instability* (AB)**: Expectation that significant others will not be available to provide support, connection, strength, or protection.
2. ***Mistrust/Abuse* (MA)**: Expectation that others will hurt, abuse, humiliate, lie, cheat, steal, or manipulate.
3. ***Emotional Deprivation* (ED)**: Expectation that one will not receive adequate emotional support or be understood by others. Three major subtypes of deprivation include:
   (a) ***Deprivation of Nurturance***: The absence of attention, affection, warmth, and companionship – 'No one cares . . .'
   (b) ***Deprivation of Empathy***: The absence of understanding and attunement – 'No one really gets me . . .'
   (c) ***Deprivation of Protection***: The absence of direction, strength, and guidance – 'I am all alone (in facing the world)'.
4. ***Defectiveness/Shame* (DS)**: Belief that one is defective, unlovable, bad, unwanted, inferior, inadequate, and/or shameful.
5. ***Social Isolation/Alienation* (SI)**: Belief that one is socially isolated, different from others, and does not belong to any group or community.

Impaired Autonomy and Performance Domain

6. ***Dependence/Incompetence* (DI)**: Belief that one is helpless and unable to cope with everyday responsibilities without significant help from others, leading to lack of autonomy and self-reliance.
7. ***Vulnerability to Harm or Illness* (VH)**: Expectation that a catastrophe is imminent, and one will be unable to prevent it.
8. ***Enmeshment/Underdeveloped Self* (EM)**: Tendency to be overly emotionally involved with one or more significant others, resulting in impaired social development, inner direction, and individuation.
9. ***Failure* (FA)**: Belief that one has failed or will fail in areas of achievement and that one is incompetent, stupid, inept, untalented, etc.

Impaired Limits Domain

10. ***Entitlement/Grandiosity* (ET)**: Belief that one is superior to others, should receive special treatment, and should not be required to follow the same rules as others.
11. ***Insufficient Self-Control/Self-Discipline* (IS)**: Inability to appropriately restrain impulses and emotions; difficulty tolerating frustration and boredom to accomplish goals.

Other-Directedness Domain

12. ***Subjugation* (SB)**: Surrender of control to others and suppression of one's own emotions and needs to avoid anger, retaliation, or abandonment.
13. ***Self-Sacrifice* (SS)**: Hypersensitivity to emotional pain and suffering in others, and a tendency to take on responsibility for their needs and feelings at one's own expense.
14. ***Approval-Seeking/Recognition-Seeking* (AS)**: Excessive emphasis on gaining approval, recognition, or attention from others, resulting in an underdeveloped authentic sense of self. Often involves overemphasis on status, achievement, and/or money.

Table 1.1 (cont.)

Overvigilance and Inhibition Domain

15. ***Negativity/Pessimism* (NP)**: Exaggerated expectation that things will go wrong, or of making mistakes, leading to excessive worry. Focusing on the negative aspects of life and minimising positives.
16. ***Emotional Inhibition* (EI)**: Inhibiting spontaneous actions, feelings (especially anger), or communication to prevent being disapproved of, ridiculed, or losing control.
17. ***Unrelenting Standards/Hypercriticalness* (US)**: Belief that whatever one does is not good enough, that one must strive to meet very high standards of performance, usually to prevent criticism; and/or excessive emphasis on status, power at expense of health and happiness.
18. ***Punitiveness* (PU)**: Belief that people (self and others) should be severely punished for making mistakes or not meeting one's internalised expectations or standards.

* *Adapted from Young, Klosko, & Weishaar (2003)*

- regarding oneself and one's relationships with others
- developed during childhood or adolescence
- elaborated throughout one's lifetime, and
- dysfunctional to a significant degree.

EMS represent patterns of self-defeating affect and cognition that begin early in development and are repeated and elaborated throughout one's lifetime. They are triggered by current situations or circumstances relevant to the schema theme.

Key to this definition is the emphasis not only on cognitive content (e.g., core beliefs, negative automatic thoughts), but the interplay between all four components of EMS activation: (1) cognitive content; (2) memory/imagery – negative memories and imagery become more salient when the schema is triggered; (3) emotions; and (4) bodily sensations. Young and colleagues' definition highlights the significance of imagery-based, affective, and somatic processes in any approach to understanding and healing schemas. Young [2] argues that EMS are usually adaptive and accurate representations of the general tone of the family and childhood environment during the developmental period but may come to bias subsequent experience outside of that family context. EMS that were relatively accurate and perhaps adaptive during childhood can be maladaptive later in adult life. It is worth noting that in Young and colleagues' view of EMS, maladaptive coping behaviours are not themselves part of the EMS but are ways of coping with the EMS. These coping behaviours are said to be 'schema-driven' rather than representing a direct component of the schema per se.

Three Broad Maladaptive Coping Styles

Young argued that EMS are perpetuated through three broad styles of coping. Each represents a different type of adaptation to the EMS and functions to provide some sense of subjective relief from the emotions involved in the activation of the EMS. The coping behaviour usually blocks access to information that would otherwise disconfirm EMS-driven expectancies and maintains a longer-term disconnection from the satisfaction of