Abstract

Objective: The compassionate mind training was designed in accordance with the structure of cognitive-behavioral therapies and the historical period of this therapeutic model is rooted in the improvement of negative emotions in cognitive-behavioral therapy. The aim of this study was to investigate the effectiveness of compassionate mind training in the adjustment of early maladaptive schemas in opiate addicts under methadone maintenance treatment. **Method:** A quasi-experimental design with pre-test-post-test-follow-up control group design was used in this study. A total of 30 male substance users (mean age = 32.5 years) were selected from two addiction treatment centers by convenience sampling method and were classified into two groups after being diagnosed with axis I disorders through a structured clinical interview. The experimental group participated in twelve sessions of Gilbert's Compassionate Mind Training Group. Participants were evaluated by Yang Primary Schema Questionnaire (short form) in three stages of before intervention, final session, and one month later (follow-up session). **Results:** The findings of this study indicated that the score of schemas in the experimental group decreased except for the schemes of abandonment/instability, mistrust/abuse, enmeshment, entitlement/grandiosity, and unrelenting standards/hypercriticalness.

Conclusion: Based on the results of this study, it can be concluded that the compassionate mind training is an effective treatment in adjusting the early maladaptive schemas among opiate addicts under methadone maintenance treatment.

Keywords: compassionate mind training, early maladaptive schema, addiction

Investigating the Effectiveness of Compassionate Mind Training (CMT) in the Adjustment of Early Maladaptive Schemas in Opiate Addicts under Methadone Maintenance Treatment

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Introduction

The presence of a serious and chronic illness in a family member typically does not only have a considerable impact on the family system, roles, performance, and quality of life of the family members, but can also affect the society. Addiction is one of the chronic diseases that disrupts family life, affects the vitality and happiness of family members and, as a result, has an adverse effect on the quality of life (Garland, Gaylord, Boettiger, & Howard, 2010). This disease is widespread around the world and today, a large proportion of the individuals with this disease are the youth who play a significant role in the current trends affecting the family environment, especially emotional relationships between the couples and their children (Hosni, Tajoldini, Jahromi and Farmani, 2014). The global annual rate of prevalence of drug users is estimated to be 30.3-60.6% in people aged 15-64 years (United Nation Office for Drug Control, 2011). In Iran, the rate of relapse of addiction has been reported from 38% to 90% (Naderi, 2004). It's not easy to calculate exact number of addicts in Iran, and there is no such figure right now.

Regarding the relevant causes of addiction, various factors such as biological, sociological and psychological problems are discussed. It seems that the definite response to opiates depends upon a combination of these factors. Of all the factors influencing the phenomenon of addiction, the existence of specific personality traits as an individual factor can be considered as even in case of the lack of providing other areas and conditions, an individual is involved in the horrible trap of addiction and plays an important role in the sustained drug use. Since the end of addiction is emerged in an individual and a few of addicts are successful in opiate quitting, again return to this maladaptive behavior and it can be said that drug addiction is probably rooted in more long-lasting structures (Sahand, Zare and Fati, 2010). In this case, studies have shown the relationship between addiction and personality disorders (Kozlov, & Buzina, 1999), such as antisocial, borderline, narcissistic, and histrionic personality disorders. The individual's personality depends on his psychological structure and is defined by certain fixed structural factors that can be considered as schemas. The concept of the schema forms the basis of cognitive theories about pathology and psychotherapy (Young, Klosko, & Weishaar, 2003). Early maladaptive schemas are destructive emotional and cognitive patterns that have been formed in the beginning of the development and evolved in the mind and are repeated in the course of life (Hamidpour and Enduz, 2010). These maladaptive schemas have different types of different types and have different severity and weakness in different people, and in different researches, the severity of some of these schemas in drug users is estimated to be higher than the normal population. In a study conducted by Jalilian and Yazdanbakhsh (2014), it was shown that the schemas of mistrust / mistreatment, dependence / insecurity, subjugation and self-efficacy/insufficient self-control were predicted drug abuse tendency. The

results of a research showed that drug addicts suffer from high levels of early maladaptive schemas, and lifestyle is incompatible in drug-dependent individuals (Pour Mohammad et al., 2013). Sahand, Zare and Fati (2010) concluded that therapeutic interventions aimed at modifying early maladaptive schemas could be effective in increasing the success rate of unsuccessful opiate addicts for quitting. Khoshlahje et al., (2009) found that there were clear differences in early maladaptive schemas in individuals succeeding in quitting or failing quitting. Also, Asadi, Amiri and Pourkmali (2010) provided empirical evidence for the assumption that early maladaptive schemas could affect the tendency of individuals to substance abuse. Ball, Cobb-Richardson, Connolly, & Bujosa (2005) in a study concluded that individuals who use adaptive schemas are more capable of adapting with psychological pressures. They are less likely to suffer from psychological problems and drug abuse. Another study on alcohol addiction and schemas showed that most alcoholics have more maladaptive schemas than normal people (Roper et al., 2010). Research findings show that early maladaptive schemas are higher among drug users than normal people (Shaghaghi, Safariniaia, Iranpour and Soltaninezhad, 2011), and these maladaptive schemas lead to anxiety, depression, drug abuse and other psychological problems.

Different research has been done to find appropriate treatment to reduce the amount of anxiety, stress, and mental disorders, as well as modifying the early maladaptive schemas. Each treatment has progressed on a subject. A very novel topic that has attracted the attention of many researchers is the notion of self-compassion, self-judgment, self-perception, and criticism and judgment about its shortcomings and incompetency. Self-compassion is a way of reducing the anxiety associated with mental disorders (Brooks, Kay, Bowman, and Childs, 2012) and although it is a new concept in Western psychology, it has been present for centuries in oriental philosophy (Sa'idi, Qobani , Sarafraz and Sharifian, 2013).

For the first time, self-compassion was defined by Neff (2003 a, b) as a three-component construct of elf-kindness versus self-judgment, common humanity versus isolation, and mindfulness versus over-identification. The combination of these three components is a personality feature that is compassionate on self. Self-Kindness and self-understanding instead of judging or criticizing shortcomings and incompetence. Confessing that all human beings are defective, make mistakes, and engage in unhealthy behaviors are characteristics of common humanity (Sa'idi et al., 2013). Mindfulness versus over-identification leads to a balanced and clear awareness of the experiences of the present time and makes it impossible to ignore the painful aspects and at the same time does not repeatedly occupy the mind (Nay, 2009).

Neff (2003) in a study reported that self-compassion has an inverse relationship with depression, rumination, suppressive thinking, self-critique and aggression. Neff, Rude, & Kirkpatrick (2007) found that increased self-

compassion led to a reduction in depression, anxiety, and suppressive thinking. In a study by Moeller, & Crocker (2009) on self-compassion relationship with alcohol and drug use, they concluded that with the decline in compassion, the likelihood of drug use is increased among college students. Rendon (2007) stated that there is a negative correlation between drug abuse, self-confidence and mindfulness in 300 psychology students.

According to studies on self-compassion, Gilbert (2005) used this structure for therapeutic purposes. By behavioral cognitive therapy, structured "Compassion Focused Therapy (CFT)" and a comparison-based therapy group approach called "Compassionate Mind Training(CMT)".

The structure of this treatment is based on the ineffectiveness of cognitive-behavioral therapies for the treatment of negative emotions (Gilbert, 2009). In fact, compassion-focused therapy facilitates the emotion regulation and difficult emotions and encourages painful emotions (Ranjbar Kohan and Nouri, 2016). Compassionate Mind Training(CMT)includes special mental psychological elements that focus on the quality of self-compassion, self-critique as a form of behavior strategy, the recognition of inner fears, the development of empathy for personal discomfort and harmless efforts and re-focusing on images, thoughts, feelings, and compassionate behaviors with warmth mental imagery techniques (Gilbert and Proctor, 2006). Some researches have recently shown the impact of Compassionate Mind Training on symptoms of depression and anxiety and self-criticism. Gilbert and Irons (2005) showed that by compassionate mind training to people, we can eliminate self-guilt, self-criticism and self-condemnation. In another study, Gilbert and Proctor (2006) reported that compassionate mind training is helpful for patients with chronic problems, especially for those with posttraumatic stress. Also, depression, anxiety, self-criticism, shame, humiliation, and subjective behavior were reduced considerably in their research.

All of these studies have been conducted in Western countries. The novelty of the concept of self-compassion, compassion-focused therapy, and compassionate mind training determine the significance of further researches. Although self-compassion has an Eastern background like Buddhism, what is true is that most scientific research has been carried out in Western countries and there has been an overwhelming majority of research in that area. Therefore, since substance abusers have an early maladaptive schema that is different from healthy people, the early maladaptive schemas bring maladaptive thought patterns and negative and inappropriate thoughts to individuals, and the compassion- focused therapy is aimed at increasing the psychological flexibility, creating linguistic self-compassion and changing negative thoughts using their own techniques. The present study attempts to develop a new form of compassionate mind training as a complementary therapy on early maladaptive schemas in drug addicts under methadone treatment in drug rehab centers.

Method

Population, sample and sampling method

A quasi-experimental design with pre-test-post-test-follow-up control group design was used in this study.

The statistical population of the study consisted of men who had referred to two outpatient addiction treatment centers affiliated to Isfahan wellbeing organization in spring 2016; 38 persons with substance abuse were selected using convenience sampling method and randomly assigned equally into two groups. During the implementation of the design, four experimental groups were excluded due to absence of more than three sessions. In order to equalize the sample size in two groups, four individuals were randomly excluded from the control group and the sample size decreased to 30. The inclusion criteria were: (1) Undergoing methadone maintenance treatment, (2) the history of opiate use (opium and its residue), (3) Age of 20 to 40 year old, (4) The diagnosis criteria for the opiate dependence based on diagnostic and statistical diagnostic manual for mental disorders (fifth edition), (5) more than two months of methadone treatment, (6) non-acute mental and physical illness, (7) minimum third of high school education. Prior to the implementation of the research, the objectives and procedure of the implementation of the design were explained for participants and the consent was obtained.

Instrument

1. Structured Clinical Interview for Disorders I: This interview is a flexible interview, provided by First et al ., (1997) and translated into Persian by Sharifi, Islami, Mohammadi and Kaviani (2005). First et al. (1997, Translated of Sharifi et al., 2005) evaluated its reliability for I disorders via test retest by seven interviewers and reported kappa coefficient of 0.7. This interview was used to diagnose opioid dependence, psychosocial disorder and bipolar disorder.

Short Form of Young' Schema Questionnaire.: This questionnaire has 75 questions. To measure 15 early cognitive maladaptive schemas including emotional deprivation, abandonment, mistrust, social isolation, defectiveness, dependency, vulnerability to harm , Enmeshment, subjugation, emotional deprivation, sacrifice, unrelenting standards, insufficient self-control, entitlement and failure. Each of the 75 items was rated on a 5-point Likert scale from "not at all true about me" to "it describes me exactly." Individual score in each schema is obtained by adding scores of 5 questions related to that schema. A high score indicates high presence of the inefficient schema and a minimum score for each schema is 5 and maximum score is 25. The standardization of scale in Iran was carried out by Ahi, Mohammadifar and Besharat in 2005 in Tehran universities. Cronbach's alpha coefficient was 0.98 in male population and 0.77 in female population.

Procedure

After the referral patients from the psychiatrist to the therapist and conducting interviews with them, based on inclusion and exclusion criteria, the subjects

selected the research instruments before the group sessions, and after 12 sessions of treatment, and one month after the completion of the meeting. The results of the study were performed by double blind study by another person other than therapist. Sessions were held weekly in one session and duration of each session was two hours at one of the Outpatient Treatment Center affiliated to the Wellbeing Organization of Isfahan. Each session was based on Gilbert's Guide to Compassion-Focused Therapy (Gilbert, 2006). In the first sessions, the logic of compassion-focused treatment and the concepts of compassion and self-compassion were introduced; later, individuals were asked to try to determine the method of thinking and behavior to themselves, during these sessions, some methods such as compassionate imagery, soothing breathing, mindfulness, empathy, writing a compassionate letter, etc. were trained to individuals to enhance self-compassion.; during the final sessions, people were encouraged to recognize the factors that caused fear and repulsion toward their component of self-compassion and confront them. At the last session and thirty days after the end of the sessions (follow-up), the maladaptive schemas test was re-implemented; the control group did not receive any psychological intervention, and only weekly attended the center and then received methadone medication after the doctor's visit and a monthly urine test.

Findings

The average age of participants was 32.5 and the education of majority of them (66%) was diploma. The descriptive statistics of the early maladaptive schemas by group and type of test are presented in Table 1.

Table 1: Descriptive Statistics of Maladaptive Schemas by Groups and Type of Test

Variables	*Groups*	*Pretest*		*Posttest*		*Follow-up*	
		Mean	*SD*	*Mean*	*SD*	*Mean*	*SD*
Emotional deprivation	Experiment	18/60	3/7	11/13	1/77	10/87	1/84
	Control	18/67	3/68	18/60	2/84	18/73	2/63
Abandonment	Experiment	19/13	2/32	18/87	2/5	18/53	2/39
	Control	19/07	2/54	18/73	2/19	19	2/03
Mistrust	Experiment	12/33	2/41	12/27	2/31	12/47	2/17
	Control	12/33	3/79	12/33	3/46	12/27	3/41
Social isolation	Experiment	19/07	1/94	11	1/65	10/80	2/21
	Control	19/07	3/08	19/07	2/89	19	2/93
Defectiveness	Experiment	19/67	2/32	10/93	2/09	11	2/14
	Control	19/73	2/52	19/47	2/64	19/80	2/45
Dependency	Experiment	15/47	2/82	10/20	2/6	10	2/54
	Control	15/53	3/09	15/47	3/60	15/47	3/98
Vulnerability	Experiment	15/67	2/53	10/47	2/17	10/13	2/36
	Control	15/73	2/05	15/80	2/88	15/73	2/55
Enmeshment	Experiment	13/40	2/75	13/20	2/6	13/13	2/75
	Control	13/67	2/66	13/80	3/03	13/60	2/67
Subjugation	Experiment	13/07	2/09	11/13	2/97	11/13	2/97
	Control	13/07	3/22	13/07	3/22	13/07	3/22
Emotional inhibition	Experiment	17/60	2/67	11/13	3/18	11/13	3/18
	Control	17/60	3/11	17/67	2/99	17/67	2/99
Self-sacrifice	Experiment	17/67	3/15	10/60	2/99	10/27	3/23

Table 1: Descriptive Statistics of Maladaptive Schemas by Groups and Type of Test

Variables	*Groups*	*Pretest*		*Posttest*		*Follow-up*	
		Mean	*SD*	*Mean*	*SD*	*Mean*	*SD*
Unrelenting standards	Control	17/53	4/03	17/40	3/83	17/27	3/07
	Experiment	18/07	3/32	17/53	3/97	17/53	3/96
Self-discipline	Control	18/27	3/63	18/20	3/12	18/33	3/33
	Experiment	19/20	2/93	12/67	3/29	12/13	3/60
Entitlement	Control	19	2/20	18/87	2/78	18/57	2/78
	Experiment	17/20	2/11	17/07	2/47	17/07	2/47
Failure	Control	17/07	1/91	17/13	2/33	17/13	2/33
	Experiment	16/27	3/24	13/73	4/5	13/67	4/44
	Control	16/27	2/43	16/27	2/43	16/20	2/37

In order to evaluate the effectiveness of the intervention, Multivariate Covariance Analysis (MANKOVA) is used. One of the assumptions of this analysis is the equation of error variances. The results of the Leven's test are presented in Table 2.

Table 2: The Results of the Leven's Test for Examining the Variance of Error in Two Groups

Variables	*Post-test*		*Follow up*	
	F statistics	**Significance**	**F statistics**	**Significance**
Emotional deprivation	1/32	0/26	0/89	0/35
Abandonment	0/23	0/65	0/11	0/74
Mistrust	0/81	0/38	1/37	0/25
Social isolation	0/73	0/20	0/38	0/53
Defectiveness	1/18	0/29	0/27	0/61
Dependency	2/23	0/15	3/22	0/08
Vulnerability	0/50	0/48	0/16	0/69
Enmeshment	0/16	0/69	0/37	0/85
Subjugation	0/01	0/92	0/01	0/92
Emotional inhibition	0/50	0/48	0/50	0/48
Self-sacrifice	0/11	0/74	0/01	0/89
Unrelentingstandards	1/33	0/26	0/79	0/38
Self-discipline	0/85	0/36	0/98	0/33
Entitlement	0/02	0/89	0/02	0/89
Failure	7/34	0/01	7/47	0/01

As can be seen, the assumption of the equality of error variances in all of the components except for the failure schema is true. To examine the assumption of the normal distribution of scores, the Shapiro-Wilk test was used and the results are presented in Table 3.

Table 3: Shapiro-Wilk Test Results to Evaluate the Normal Distribution of Variables by Groups

Variables	*Groups*	*Shapiro statistics*	*Significance*	*Variables*	*Groups*	*Shapiro statistics*	*Significance*
Emotional deprivation	Experiment	0/86	0/12	Subjugation	Experiment	0/95	0/57
	Control	0/90	0/11		Control	0/90	0/11
Abandonment	Experiment	0/95	0/56	Emotional inhibition	Experiment	0/96	0/78
	Control	0/93	0/25		Control	0/91	0/13
Mistrust	Experiment	0/95	0/58	Self-sacrifice	Experiment	0/94	0/36
	Control	0/87	0/44		Control	0/93	0/37

Table 3: Shapiro-Wilk Test Results to Evaluate the Normal Distribution of Variables by Groups

Variables	*Groups*	*Shapiro statistics*	*Significance*	*Variables*	*Groups*	*Shapiro statistics*	*Significance*
Social isolation	Experiment	0/97	0/39	Unrelenting standards	Experiment	0/97	0/95
	Control	0/96	0/66		Control	0/92	0/21
Defectiveness	Experiment	0/95	0/56	Self-discipline	Experiment	0/98	0/95
	Control	0/91	0/14		Control	0/94	0/39
Dependency	Experiment	0/94	0/37	Entitlement	Experiment	0/94	0/45
	Control	0/93	0/29		Control	0/95	0/66
Vulnerability	Experiment	0/92	0/19	Failure	Experiment	0/95	0/55
	Control	0/94	0/45		Control	0/89	0/08
Enmeshmentt	Experiment	0/91	0/18	-	-	-	-
	Control	0/96	0/69		-	-	-

As shown, in all variables the normality of distribution in both groups is established. To evaluate the equality of the covariance matrix, the results of the Leven's test indicated a violation of this assumption in post-test scores (M box=11.08, F=3.52, P<0.05)). Therefore, Pillai's effect is used as a multi-variable index. The results of multivariate covariance analysis showed a significant difference between the two groups in the linear composition of variables (Pillais effect=0.73, F=4.36, P<0.01). To study patterns of difference, univariate covariance analysis was used as shown in Table 4.

Table 4: Univariate Covariance Analysis Results to Examine Patterns of Differences in Maladaptive Schemas in Post-Test Scores

Variables	*Mean of squares*	*F statistics*	*Significance*	*Effect size*
Emotional deprivation	414/71	141/83	0/0005	0/84
Abandonment	0/05	0/03	0/86	-
Mistrust	0/04	0/03	0/86	-
Social isolation	489/03	175/83	0/0005	0/87
Defectiveness	540/50	162/92	0/0005	0/86
Dependency	203/93	43/11	0/0005	0/62
Vulnerability	209/54	52/18	0/0005	0/66
Enmeshment	0/85	0/95	0/34	-
Subjugation	28/03	20/95	0/0005	0/44
Emotional inhibition	320/13	249/39	0/0005	0/90
Self-sacrifice	359/03	293/01	0/0005	0/92
Unrelenting standards	1/67	1/38	0/25	-
Self-discipline	305/25	83/79	0/0005	0/76
Entitlement	0/36	0/66	0/42	-
Failure	48/13	13/52	0/001	0/33

As shown in Table 4, there is a significant difference between the two groups in all of the schemas, except for abandonment schemes, mistrust, enmeshment, unrelenting standards, and entitlement in other schemas. In other words, the scores were reduced.

Multivariate covariance analysis was used to assess the effectiveness of intervention. To evaluate the equality of the covariance matrix, the results of the Leven's test indicated the establishment of this assumption in follow-up scores (M box = 0.12, F=1.12, P>0.05). Therefore, the Wilks' Lambda Index is used as a multi-variable index. The results of multivariate covariance analysis showed a significant difference between the two groups in the linear composition of variables (Wilks Lambda=0.68, F=4.02, P<0.01). To study the patterns of difference, univariate covariance analysis was used as shown in Table 5.

Table 5: Univariate Covariance Analysis Results to Examine Patterns of Differences in Maladaptive Schemas in Follow-up Scores

Variables	*Mean of squares*	*F statistics*	*Significance*	*Effect size*
Emotional deprivation	460/96	147/95	0/0005	0/85
Abandonment	2/01	1/32	0/26	-
Mistrust	0/30	0/20	0/66	-
Social isolation	504/30	203/16	0/0005	0/88
Defectiveness	575/27	180/50	0/0005	0/87
Dependency	219/89	36/15	0/0005	0/57
Vulnerability	232/08	50/63	0/0005	0/65
Enmeshment	0/37	0/30	0/58	-
Subjugation	28/03	20/95	0/0005	0/44
Emotional inhibit	320/13	249/39	0/0005	0/90
Self-sacrifice	379/90	183/22	0/0005	0/87
Unrelenting standards	2/68	2/53	0/12	-
Self-discipline	358/00	71/60	0/0005	0/73
Entitlement	0/36	0/66	0/42	-
Failure	48/13	12/74	0/001	0/32

As shown in Table 5, in all schemas except abandonment, mistrust, enmeshment, unrelenting standards and entitlement, there is a significant difference between the two groups in other schemas. In other words, therapy has survived. Therefore, the compassion-focused therapy program has had an effect on reducing or modifying the schemas in the experimental group, which has sustained for thirty days.

Discussion and Conclusion

The purpose of this study was to investigate the effect of compassion-focused therapy as a complementary therapy on the early maladaptive schemas in opiate addicts under methadone maintenance treatment in addiction treatment centers. The results of the visual analysis of the research showed that compassionate mind training was effective on the early maladaptive schemas of the sample. Also, follow-up sessions that were held one month after the treatment, modified schemas were applicable. According to research findings (Jalilian and Yazdanbakhsh; 2014; Pourmohammad et al., 2013; Brummett, 2007), the prevalence of maladaptive schemas in males with substance use is higher than normal individuals. Maladaptive schemas do not directly lead to a specific

disorder, but increase individual vulnerability to disorders (Haljin and Whitburne, translation by Seyyed Mohammadi, 2005). The high scores of maladaptive schemas in drug-dependent individuals indicate that they have experienced traumatic experiences in their childhood and adolescence; experiences that create a negative and maladaptive perspective to self and the surrounding world.

Although there has never been an exact randomized controlled trial on the effect of compassion- focused therapy on the adjustment of maladaptive schemas of addicts under treatment, many studies on compassion-focused therapy suggest the efficiency of this therapy in various disorders. (Brooks et al., 2012; Neff, Kristin, & Germmer; 2012; Gilbert; 2010; Goss, & Allan; 2010; Lowens; 2010). The results of this study are consistent with the studies conducted by Gilbert and Irons (2005) and Gilbert and Proctor (2006) on compassion-focused therapy.

According to the results of this study and previous studies, the effectiveness of compassion-focused therapy can be confirmed again. In many people with severe early maladaptive schemas, traumatic experiences can be traced in childhood and adolescence, leading to maladaptive beliefs about their current lives. This finding associates more recent psychiatric approaches to addiction, which addiction is considered the basic deficiencies in the person's growth and emotion (Rosnehan and Seligman, Translated by Seyyed Yahya Seyyed Mohammadi, 2007). Medications are used to reduce the annoying emotional state or as an internal defense mechanism, and the drug is also considered as a reflection of the deficiencies of the given subject or topic; in this view, the drug is used as an external temporary aid to maintain a sense of well-being. (Rosnehan and Seligman, Translated by Seyyed Yahya Seyyed Mohammadi, 2007). Compassion-focused therapy acts like mind physiotherapy in these individuals, that is, by stimulating the relieving system and increasing the internal reinforcement, provides the ground for its development, and as the system evolves, maladaptive beliefs and schemas are decreased. According to the results of this study, compassion-focused therapy has a significant effect on modifying the following schemas: emotional deprivation, social isolation, defectiveness, dependency, vulnerability, subjugation, emotional inhibition, self-sacrifice, self-discipline and failure.

Emotional deprivation, social isolation, and defectiveness / shame include abandonment and exclusion field. This area includes people who can not provide safe and satisfying attachments to others. Such people believe that their need for stability, security, affection, love, and belonging will not be met. Their main families are usually instable (abandonment / instability), abuse (mistrust / abuse), cold and lack of affect (emotional deprivation), rejection (defectiveness / shame) or isolation (social isolation / alienation). According to the results of the research in this area (disconnection / rejection), three schemas of emotional deprivation, social isolation and defect / shame showed significant adjustment. Regarding the adjustment of emotional deprivation schema, it can be said that compassion-

focused therapy refers to the fact that patients often use maladaptive thinking patterns and negative thoughts (Nobody likes me) and because they were cold and unaffectionate families, they were involved in this schema. This treatment focuses on these false patterns and replaces self-kindness with self-judgment. Those who have emotional deprivation schema do not expect their desire to be emotionally satisfied with others adequately. We have identified three types of emotional deprivation: 1. Affect deprivation (lack of affection or attention); 2. Empathy deprivation (not listening to one's inner voice); 3. Support deprivation (no guidance from others). Compassion-focused therapy has different techniques that these techniques can modify patient schemas and ultimately successful resolution of these deprivations. Among these techniques, we can refer to empathy increase for personal distress, subjective imagery, re-focusing on images, thoughts, feelings, and kind behaviors. The social isolation schema is the second scheme in this area that has been reduced in this study. People with this schema feel different from others and are the black sheep of society. In fact, this schema is a sense of a person's difference or disagreement with the community. Usually, patients with this schema do not feel attached to any group or society. Compassion-focused therapy is considered as a useful emotional-focused coping strategy. Because self-compassion requires the conscious awareness of its emotions, no longer avoid painful and distressing feelings, but we approach them with kindness, understanding, and the sense of common humanity. Self-compassion also helps to activate its relieving system and thus reduces the sense of fear and isolation in individuals (Gilbert & Irons, 2005). The defect / shame schema is the third schema in disconnection and rejection field that after the compassion-focused therapy, there was a significant decrease in this schema. Patients with defect / shame schema feel that they are incomplete, bad, humble, and worthless, and if they are exposed to others, they will certainly be rejected. The results of this study are consistent with the findings of Gilbert and Iron (2005), show showed that by the compassion-focused therapy , shame can be eliminated. The feeling of shame is a painful excitement that is accompanied by humiliation, worthlessness and disability and compassion-focused therapy self- improves symptoms of self-shame by self-awareness and logical evaluation. The present paper shows the difference of scores in posttest of success of this therapy to reduce this feeling.

The dependency schema, vulnerability to harm /illness, and failure are in the field of impaired autonomy and performance as the result of which compassion-focused therapy can have a significant effect on the post-test scores of patients. The high scores of drug- dependent persons in impaired autonomy and performance schema include failure, dependency / incompetence, vulnerability to harm / illness, show that these people experience maladaptive beliefs in incompetence and helplessness, experience sacrifice and loss of individuality. The traumatic experiences of childhood and the rejecting environment cause children to expect others to harm them (Salavati and Yekkeyazdandust, 2010).

The schemas of this field are commonly found in families that reduce their children's self-confidence. In the treatment sessions, it was tried to help patients to identify the factors that caused their fear and repulsion toward the component of self-compassion, which in turn help to increase the sense of self-confidence and increased patient competence. When someone attempts to be kind with himself instead of self-judgment, , and with his understanding, instead of judging or criticizing his shortcomings and failures, he can achieve a better feeling, and admitting that all human beings are defective, make mistakes and engage in unhealthy behaviors, can increase his self-confidence. This issue weakens the severity of the autonomous schemas and the impaired performance. Another reason to increase the sense of self-confidence of the patients and reduce the impaired autonomy and performance schemas is the practice of skills in the group, knowing the other's feelings and learning empathy. The fact that a person in the group can express his or her feelings without any condition or judgment, is a very important factor in improving interpersonal skills, self-control, and increasing sense of self-esteem.

In other- directedness domain (schemas of subjugation and sacrifice), modification of the schemas was also observed. Schemes in this area are seen in families that have accepted the child on an ad hoc basis. In the subjugation schema, the person feels compelled to delegate his control to another person. Compassion- focused therapy, by enhancing positive emotions and recognizing positive thinking, gives the individual the power to rely on his own feelings and emotions rather than deciding on his affairs. In the self-sacrifice schema, the individual only thinks about meeting the extreme needs of others without considering his own needs. This therapy returns the direction of the arrow to the person with self-kindness technique and educates him towards a kindly behavior. In the area of overvigilance and inhibition (emotional inhibition schema), we are also faced with a decrease in the scale. In this schema, the individual behaves with the extreme inhibition of acts, emotions and spontaneous communication in order to avoid the rejection by others, shame and lose control of personal impulses. When a person becomes acquainted with his positive and negative emotions and finds a balanced and clear awareness of the experiences of the present, it is easier to communicate with others without feelings of rejection and is not embarrassed to express his emotions.

In the area of impaired limitations (self-discipline-inadequate self-discipline schema), schema modification was observed. Individuals with this scheme have constant problems in proper self-discipline and failing to achieve personal goals or inability to prevent the expression of emotions and impulses as the compassion- focused therapy by emphasizing on the recognition of emotions, awareness of positive emotions, compassionate imagery, relieving breathing, mindfulness, empathy, writing a compassionate letter has diminished the intensity of this schema. Of course, there were no significant modifications in addition to the modified schemas in the five types of schemas (abandonment /

instability, mistrust / abuse, enmeshment, entitlement / grandiosity, unrelenting standards / Hypercriticalness).

In sum, these results showed that compassion-focused therapy is effective in reducing the early maladaptive patterns of the research sample, but for the maximum effectiveness and effect of treatment on other schemas, attention should be paid to the points that can be referred to as limitations of the study is necessary: firstly, the number of treatment sessions can be designed for more than 12 sessions, as the increase number of sessions can help the exercise of concepts, and this will be effective in modifying the schemas. Because understanding and communicating with the concept of self-compassion for many individuals, especially in particular schemas, is harder than the rest, and since the first experiences of the life and the quality of the attachment system of the a person is an important factor in shaping the character of self-compassion, this feature is rooted in deep- personality structures (Gilbert, 2005). Therefore, we need its developing to individual and long-term sessions than group therapy. The second case, which can be noted, is the short duration of research follow up, which, by conducting long-term studies, and long-term and multi-stage follow-ups, provides more complete results on the sustainability of this therapeutic model to the researchers over time.

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