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The Use of Schema Therapy and Acceptance and Responsibility Therapy in Working with People with Fixed Behavioural and Thought Patterns

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Abstract

Background: Rigid cognitive-behavioural patterns pose a serious therapeutic problem because persistent patterns of avoidance, emotional fixation, and low psychological flexibility accompany them. In this regard, it is essential to seek integrated approaches that can combine a deep conceptualisation of personal structures with process efficiency.

Objective: The purpose of this study is to evaluate the effectiveness of an integrated model of psychotherapeutic intervention, combining schema therapy and acceptance and commitment therapy (ACT), in working with individuals who exhibit rigid cognitive-behavioural patterns.

Methodology: The theoretical analysis and pilot empirical research with the help of AAQ-II and YSQ-S3 psychometric scales are the methodological base of the study. The empirical part was executed in the form of a one-group pretest-posttest, with quantitative data being analysed using paired-samples t-tests in SPSS to confirm changes within groups. Moreover, observation, which was done qualitatively throughout the sessions, was employed to supplement numerical outcomes and add to the validity of interpretation.

Result: Following the therapeutic intervention, a decrease in the intensity of the five central maladaptive schemes and a significant improvement in psychological flexibility were observed. The greatest changes were found in the schemas of emotional deprivation, self-punishment, and unattainable standards, indicating the high sensitivity of these structures to the combined effects of schema therapy and ACT techniques.

Conclusion: The developed model covers five stages of intervention – from diagnosis to consolidation of changes – and includes both cognitive-emotional and behavioural-value techniques.

Unique Contribution: The study's practical significance lies in the creation of a structured toolkit for working with rigid clients, which can be applied in clinical practice and the professional training of therapists.

Key Recommendation: The results allow us to outline the prospects for further research, in particular in the direction of long-term effect, personalisation of interventions and scaling the model in different therapeutic formats.

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Keywords: schema therapy, acceptance and responsibility therapy (ACT), rigidity, cognitive schemas, psychological flexibility, integrated psychotherapy, coping strategies, emotional regulation.

Introduction

In modern psychotherapeutic approaches, special attention is paid to the problem of rigidity as a persistent personality characteristic that complicates emotional regulation, cognitive flexibility, and adaptive behaviour. Individuals with rigid cognitive-behavioural patterns typically exhibit a high level of psychological resistance to change, a fixation on past experiences, and a limited ability to reevaluate their thoughts, emotions, and behavioural patterns. This presents a significant challenge to the therapist, particularly where there are personality disorders, chronic anxiety, depression or an avoidance tendency. Schema therapy provides the means of profound conceptualisation through the use of early maladaptive schemas, dysfunctional modes, and coping strategies (Fassbinder et al., 2016; Dadomo et al., 2016), whereas the objective of ACT is to establish the capacity to act and think (psychological flexibility), minimise thought fusions, and create value-congruent behaviour (Apolinário-Hagen et al., 2024; Yu et al., 2025). Particular empirical studies show that each of the approaches is successfully applied, namely, with the assistance of managing emotional dysregulation, depression and anxiety, obsessive-compulsive disorder, and avoidant behaviour (Leahy, 2019; Baljé et al., 2024; López-Pinar et al., 2025). Although there exists a considerable range of both theoretical and clinical advances, integration of schema therapy and ACT is still a relatively novel direction that has not yet been provided with systematic empirical backing. Specifically, no data exist on the long-term outcome of combined treatment, the mechanisms of its impact on fixed schematic structures and the mechanisms of changes in rigid coping. It is also necessary to develop a generic intervention model that integrates the conceptual richness and practical success of both approaches in their application to the problems of clients with a history of chronic, maladaptive patterns.

Due to the limited knowledge about the combined effect of the applied therapy and ACT, there is a need to investigate potential gaps in the current study on individuals with deeply ingrained maladaptive patterns. This study aims to develop an integrated model that can be applied in clinical practice, featuring a clear, structured, and empirically based intervention protocol.

Hypotheses:

H1: The participants of the integrated intervention will statistically improve on the intensity of the maladaptive cognitive schemas.

H2: The intervention will result in a significant improvement in psychological flexibility among participants.

Against this background, this research study aims to explore the effectiveness of an integrated model of psychotherapeutic intervention in terms of the combination of schema therapy and ACT in treating patients with rigid obligatory cognitive and behavioural patterns. In order to accomplish this objective, the authors are going to: (1) describe the key elements of rigidity in cognitive, emotional, and behavioral domains; (2) outline the specifics of schema therapy and ACT methods in terms of their use within the framework of the designated target population;

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(3) formulate an amplified picture of synthesized intervention; (4) preliminarily test the efficacy of the suggested approach empirically.

Literature Review

Schema therapy and ACT are becoming popular solutions to dealing with personality disorders with emotional rigidities, cognitive fixation, and complaintive maladaptive schemas (Fassbinder et al., 2016; Dadomo et al., 2016; Amani et al., 2025; Yu et al., 2025) in the contemporary science discourse. Both clinical outcomes and theoretical progress in therapeutic mechanisms, specifically in models such as hexaflex and regimen work, confirm the relevance of studying these methods (Apolinário-Hagen et al., 2024; Faustino et al., 2024; Baljé et al., 2024). Emotional dysregulation is a key focus of numerous studies as a primary target of psychotherapy, particularly in the context of personality disorders (Leahy, 2019; Salgó et al., 2021; Lin et al., 2023). The articles by Lobbestael et al. (2008) prove the success of the use of schema therapy conceptualisation when treating rigid clients, and Yu et al. (2025) and López-Pinar et al. (2025) ensure the viability of ACT as a tool to help reduce the levels of cognitive fusion and avoidance.

The combination of approaches is particularly interesting, as the integration of cognitive reconstruction, imaginary rewriting, and acceptance demonstrates increased effectiveness compared to the traditional version of CBT (Faustino et al., 2024; Amani et al., 2025). This is also confirmed by the findings of clinical trials in the treatment of depression, anxiety disorders, and behavioural peculiarities (Apolinário-Hagen et al., 2024; Baljé et al., 2024; Giroux & Smith, 2024). Another aspect of the literature involves answering the question of neurobiological processes underlying psychotherapeutic processes, particularly in articles based on dialectical models (Lin et al., 2023; Schlagenhauf & Sterzer, 2023). It is also presented in experimental and theoretical reviews on schema therapy benefits in the work with comorbid conditions like addictions or posttraumatic reactions (Talbot et al., 2024; Alsubaie, 2024; Koliadenko et al., 2022). Confirmation of the importance of cognitive-behavioural mechanisms in changing response patterns is present in works covering both classical CBT (Beck et al., 2023; Thase et al., 2024) and its latest adaptations in the educational and rehabilitation context (Derevyanko, 2023). Thus, the accumulated empirical base demonstrates the effectiveness of integrated approaches that combine the deep conceptualisation of schemas with the process flexibility of ACT.

A separate body of research focuses on the adaptation of schema therapy to specific clinical contexts, in particular in working with geriatric patients and in comorbid conditions where rigidity is exacerbated by somatic or neuropsychiatric changes (Giroux & Smith, 2024; Schlagenhauf & Sterzer, 2023). One of the fields that can instead be seen as promising is the use of remote forms of integrated psychotherapeutic programs, especially in the post-COVID recovery environment, because in such a way, it is again possible to achieve flexible intervention without the loss of effect (Koliadenko et al., 2022; Apolinário-Hagen et al., 2024).

Strategies based on emotional schemes also take a leading role in the modern circle of discussion. For example, Alsubaie (2024) systematises the effectiveness of emotional schema therapy in dealing with mental disorders, emphasising the importance of emotional meta-awareness. At the same time, Leahy (2019) highlights the integral role of emotional schemas

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in shaping automatic patterns of action and experience, making change significantly more challenging without the involvement of deep therapeutic tools.

Theoretical sources also provide an expanded understanding of cognitive behavioural therapy as a foundation for the development of innovative psychotherapeutic areas. For example, Beck et al. (2023) and Thase et al. (2024) provide modern perspectives on the development of CBT as a scientific discipline, highlighting its capacity to integrate with new approaches. Methodological materials, such as Derevyanko's (2023) manual, promote the institutionalisation of CBT in educational programs, which creates the basis for the wider dissemination of effective therapeutic practices.

Thus, there is a significant theoretical and practical body of research on the use of schema therapy, ACT, and their integration to overcome rigid cognitive and behavioural patterns. However, the issues of the long-term effect of such interventions after the completion of therapy and mechanisms for maintaining changes in conditions of high risk of relapse remain unresolved.

Methods

The current research setting was a pre-experimental one-group pretest-posttest study, intended to estimate the performance of an integrated psychotherapeutic intervention. The population group consisted of adults aged between 28 and 45 years (M = 36.2) who attended the Centre of Cognitive Behavioural Therapy and Personal Development in Kyiv from January to March 2025 and sought to apply therapy in their lives. Participants (n = 12) were recruited using a purposive sampling scheme with exclusionary criteria associated with common complaints, including persistently experiencing cognitive-behavioural stuckness, being chronically emotionally dysregulated, being perfectionistic, and the usual inability to alter their maladaptive ways of doing things. Every informant signed an informed consent form before participating in the study.

A professional, trained in the practice of schema therapy and Acceptance and Commitment Therapy (ACT), performed and created the intervention protocol used. It consisted of cognitive-emotional, behavioural-value treatment, which addressed maladaptive schemas and psychological inflexibility. Clients were subjected to 12 individual sessions (one session per week, 60 minutes each) within a total of around 10 weeks. The intervention fidelity was ensured through a standardised protocol procedure, which tracked sessions and supervised records.

Measurement of Psychological Flexibility: Psychometric assessments of psychological flexibility were conducted before and after the intervention using the Acceptance and Action Questionnaire-II (AAQ-II). Measurement of the Level of Critical Maladaptive Schemas: Prior to and after the intervention, the intensity of five most critical maladaptive schemas were measured and assessed (emotional deprivation, dependence/incompetence, punishment, unattainable standards, and self-sacrifice) using the Young Schema Questionnaire- Short Form 3 (YSQ-S3) Internal consistency of both instruments has been proved to be high in earlier research, and the alpha Cronbach values concerning all the scales in the actual sample appeared to vary between .82 and .89, which means an acceptable reliability was achieved. The studies were conducted under supervision during data collection, utilising self-reporting questionnaires. The descriptive statistics and paired-samples t-tests were used to explain the

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scores earned and how psychological indicators changed, with unique emphasis on the direction and magnitude of change in both instruments. Every process was carried out in regard to the ethical principles of the Declaration of Helsinki and the Code of Ethics of the Ukrainian Psychological Association. The protocol of the study was discussed and accepted by the Ethical Committee of the Centre of Cognitive Behavioural Therapy and Personal Development (Kyiv, Ukraine). All the participants were informed through written consent before being included in the research.

Results

The results of the pilot study are presented below, focusing on changes in psychological flexibility and maladaptive schemas following the intervention. Schema therapy, developed as an extension of classical cognitive-behavioural therapy, offers a more flexible and in-depth toolkit for working with chronic and persistent personality disorders, where early maladaptive schemas and related modes play a particularly important role (Lobbestael et al., 2008; Fassbinder et al., 2016). Scientific works indicate that dysfunctional modes of thinking and behaviour, formed based on non-integrated emotional needs, complicate the therapeutic dynamic and cause rigidity in the client's perception, emotional reactions, and interpersonal relationships (Dadomo et al., 2016; Baljé et al., 2024).

Schema therapy emphasises the integration of cognitive, emotional, and behavioural components of the personality through the conceptualisation of schemas and modes, which is especially valuable when working with rigid clients who resist change or have chronically fixed patterns of avoidance, overcompensation, or submission. For example, within the framework of the "two chairs" technique or imaginal rescripting, the client learns to rethink their own internal states not only on the cognitive but also on the experiential level (Fassbinder et al., 2016). These tools help to reduce the intensity of the impact of rigid patterns and activate a "healthy" mode, which, in turn, contributes to greater psychological flexibility. Acceptance and Responsibility Therapy, in turn, operates with the concepts of psychological elasticity, contextualised behaviour, thought fusion, cognitive diffusion, and life values as guidelines for change (Amani et al., 2025; Apolinário-Hagen et al., 2024). Individuals with rigid cognitive-behavioural attitudes are characterised by a high level of cognitive fusion - identification with thoughts and beliefs that are perceived as absolute truth rather than as mental events that can be observed without losing contact with reality. ACT therapeutic tools help these clients learn the skills of "stepping back" from thoughts and feelings without avoidance, which reduces emotional distress while maintaining the authenticity of life experience (López-Pinar et al., 2025; Yu et al., 2025).

Both schema therapy and ACT aim to change patterns of self-observation and interaction with one's own cognitive-affective processes. However, they operate through different mechanisms: while the former works through transformation and rescripting schemas, the latter works through acceptance, distancing, and value orientation. Their combination allows us to expand the scope of influence on rigidity: on the one hand, to modify the basic schemas that underlie rigid behaviour, and on the other hand, to strengthen the personal ability to act in the direction of what is important despite the presence of discomfort. This approach is especially important when working with people with personality disorders or chronic depression, where traditional

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forms of cognitive therapy may not be flexible or effective enough (Faustino et al., 2024; Amani et al., 2025; Apolinário-Hagen et al., 2024).

In this way, the theoretical evaluation confirms the expediency of combining schema and ACT as complementary approaches to the perception of rigid cognitive-behavioural patterns. This paves the way to more empirical studies to determine the level of effectiveness of combined approaches in long-term practice of psychotherapy.

The characteristics of rigid cognitive schemas, dysfunctional modes, and coping mechanisms that provide obstacles, making it almost impossible or hard to change the manner in which clients behave and regulate their emotions, are also an important inquiry in the schema therapy approach. Such structures are constructed according to the first negative experiences, and they are established in terms of fixed forms of thoughts, feelings, and behaviours. There is a tendency for rigid schemas to behave automatically, leading to a habitual manner of responding which is not open to flexible analysis and revisions. These clients tend to trigger maladaptive modes: those of an abandoned child, punitive parent, or submissive subordinate, which are coupled with inflexible coping behaviours: avoidance, overcompensation, or excessive compromise (Lobbestael et al., 2008; Fassbinder et al., 2016; Salgó et al., 2021). Reluctance to an elasticity also accompanies the obsession with such a negative self-description inside the head, which has no other possible interpretation of the events and the experiences. To gain a clear global picture of the links between cognitive schemes, modes, and coping, their key features are highlighted in Table 1.

Table 1. Characteristics of rigid cognitive schemas, dysfunctional modes and coping strategies

Component	Description	Typical manifestation at the client's place
Stiff cognitive schemas	Persistent negative beliefs about oneself, others, and the world	“I am worthless”, “People always betray”
Dysfunctional modes	Temporarily activated patterns of thinking, emotions and behaviour	“Abandoned child” and “Punishing parent” modes
Copying strategies	Maladaptive ways of emotional and behavioural self-defence	Avoidance (emotional, behavioural), hypercontrol
Stiffness in behaviour	Repeatable automated responses regardless of context	Ignoring new opportunities, fear of change
Emotional rigidity	Inability to flexibly regulate affects	Chronic anxiety, outbursts of anger, and emotional numbness

Source created by the author based on (Lobbestael et al., 2008; Fassbinder et al., 2016; Salgó et al., 2021)

The characteristics presented in the table enable us to understand better why traditional approaches may be ineffective for clients with high rigidity. It is the awareness and modification of schemes and regimens, as well as the replacement of maladaptive coping with functional response mechanisms, that are the basis for therapeutic progress in working with such individuals.

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Effective psychotherapeutic intervention with individuals who exhibit rigid cognitive-behavioural patterns requires not only a conceptual understanding of their schematic organisation, but also the use of targeted tools that can alter deep-seated patterns of perception, thinking, and response. Both Schema Therapy and Acceptance and Commitment Therapy (further referred to as ACT) offer a set of techniques that can be adapted to the specifics of a person's rigid structure. Schema therapy methods, such as the chair technique, imaginal rescripting, and emotionally focused interventions, aim to activate affective experience, reconstruct the past, and differentiate internal parts of the personality (Fassbinder et al., 2016; Dadomo et al., 2016). At the same time, ACT focuses on developing psychological elasticity by mastering the processes of cognitive diffusion, acceptance, and value orientation (Amani et al., 2025; Yu et al., 2025). Table 2 summarises and systematises the key techniques of these two approaches in the context of their application to clients with rigid patterns.

Table 2. Basic techniques of schema therapy and ACT in working with rigid cognitive-behavioural models

Approach	Technique.	The essence of technology	Target for the stiff customer
Schema therapy	Chair technology	Detection and dialogue between different client modes	Awareness of conflicts between the “punishing parent” and the “child”
	Imaginative rescripting	Reliving traumatic experiences with new emotional interpretation	Reducing the impact of past schemes on current operations
	Mode operation	Strengthening the “healthy adult”, validating needs	Getting out of the dysfunctional mode through support and structure
	Emotional expression	Targeted activation of repressed emotions	Restoring affective flexibility
ACT	Hexaflex	A 6-component model: values, action, contact with the moment, etc.	Building an elastic response to internal and external influences
	Cognitive diffusion	Distinguishing between thoughts and “I”	Eliminating identification with rigid beliefs
	Working with values	Identification and actualization of the value direction of life	Replacing destructive motivation with constructive motivation
	Acceptance	Allowing negative experiences to exist without avoidance	Increase tolerance to discomfort

Source created by the author based on (Fassbinder et al., 2016; Dadomo et al., 2016; Amani et al., 2025; Yu et al., 2025)

Thus, the combination of techniques from two methodologically compatible approaches allows for a flexible response to various manifestations of rigidity, from rigid cognitions and affective alienation to avoidance of change and inflexibility of behavioural scenarios. The use of these tools in a complementary format creates conditions for a more profound and more sustainable psychotherapeutic transformation.

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For clients with rigid cognitive-behavioural patterns, an integrated psychotherapeutic approach that combines the depth of conceptualisation of schema therapy with the process-oriented flexibility of ACT is most effective. Schema therapy provides a structural framework through the identification and modification of dysfunctional modes and schemas. At the same time, ACT helps to build the ability to stay in touch with one's own experience and act in accordance with values despite psychological discomfort. Below is a generalised model of intervention that integrates these approaches to increase psychological flexibility (Table 3).

Table 3. Generalised model of integrated intervention for people with rigid cognitive and behavioural patterns

Intervention stage	Tasks of the stage	Schema therapy techniques	ACT techniques	Expected results
1. Diagnostic and conceptual	Identification of dysfunctional schemes, modes and copies	Schematic conceptualisation, questionnaires	Determination of the level of fusion, elasticity (AAQ-II)	Understanding the structure of stiffness, motivation to change
2. Awareness and differentiation	Increase metacognition of internal parts and reactions	Chair technique, mode of operation	Diffusion, observation of thoughts	Awareness of "I as an observer", reduction of fusions
3. Rescripting and emotional processing	Reliving traumatic events and integrating emotions	Imaginative rescripting, emotional expression	Acceptance, working with bodily reactions	Reduction of emotional rigidity, normalisation of experiences
4. Value-based behavioural adjustment	Developing alternative ways of acting based on values	Activation of the "healthy adult"	Identification of values, committed action	Moving from avoidance to focus on meanings
5. Fixing the changes	Stabilising new behavioural patterns in real life	Repeated work with modes, case analysis	Action planning, mindfulness exercises	Increasing psychological flexibility and self-regulation

Source created by the author based on (Dadomo et al., 2016; Fassbinder et al., 2016; Amani et al., 2025; Yu et al., 2025; Baljé et al., 2024)

The proposed model provides a step-by-step transition from diagnosis to active behaviour change, taking into account both the deep structure of cognitive impairment (through schema therapy tools) and functional flexibility of response (through ACT processes). This allows not only to reduce symptoms but also to create prerequisites for long-term adaptation by increasing psychological flexibility and self-fulfilment of the client within their value paradigm.

To test the effectiveness of an integrated model of psychotherapeutic intervention combining schema therapy and acceptance and responsibility therapy, a pilot empirical study was conducted using psychological testing before and after the intervention course. The focus was on assessing the dynamics of psychological flexibility and the intensity of rigid cognitive schemas. The relevance of this approach is due to theoretical data on the complementarity of the mechanisms of both approaches and their effectiveness in working with clients who

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demonstrate chronic schematic patterns of thinking and behaviour (Dadomo et al., 2016; Fassbinder et al., 2016; Amani et al., 2025; Yu et al., 2025).

The study involved 12 people aged 28 to 45 (mean age, 36.2 years) who, in January-March 2025, sought help at the Centre for Cognitive Behavioural Therapy and Personal Development in Kyiv. The reasons for the visit were complaints of emotional rigidity, perfectionism, chronic anxiety, and difficulties in overcoming automatic maladaptive behavioural patterns. Before starting the therapy course, all participants were tested using two validated scales:

1. Acceptance and Action Questionnaire – II (AAQ-II) – to assess psychological flexibility (Appendix A);
2. Young Schema Questionnaire – S3 (YSQ-S3) – to assess the intensity of the five most common rigid schemas (emotional deprivation, dependence, punishment, unattainable standards, self-sacrifice) – Appendix B.

After completing 12 sessions of integrated therapy, which combined the techniques of "imaginal rescripting", "chair technique", cognitive diffusion, value work, and hexaplexy, participants re-filled out the same instruments. The table in Appendix C presents the primary data of 12 participants who were assessed before and after the integrated psychotherapeutic intervention on the scales of psychological flexibility (AAQ-II) and five rigid cognitive schemas (YSQ-S3). To illustrate the dynamics of changes in key psychological indicators as a result of an integrated psychotherapeutic intervention, it is advisable to refer to Figure1, which shows a comparison of mean values (M) before and after therapy on the AAQ-II and YSQ-S3 scales.

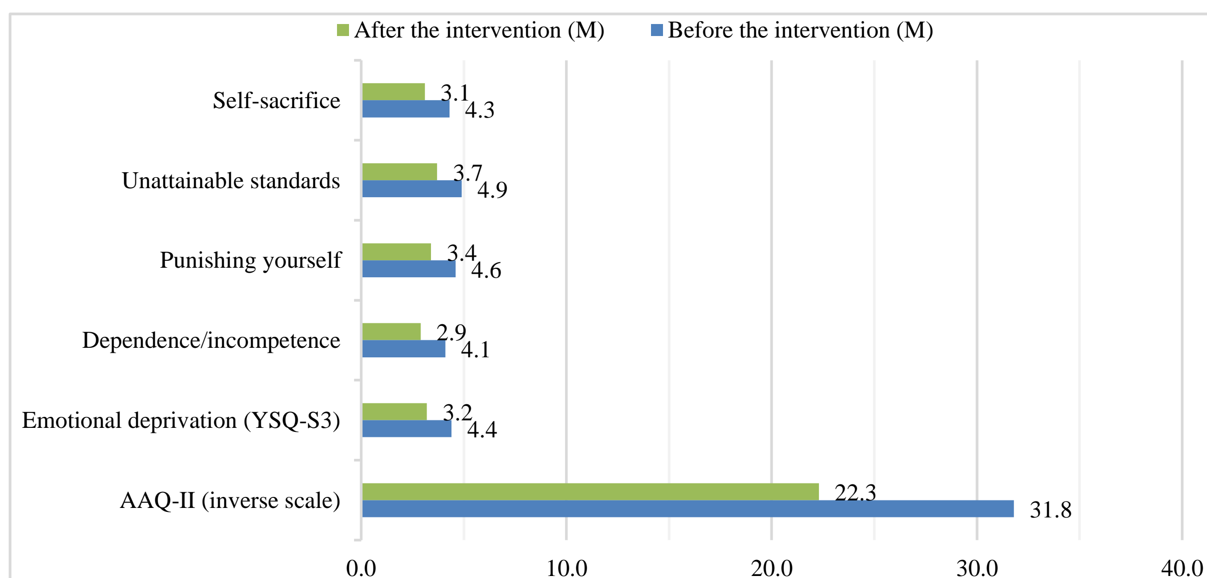

Figure1. Dynamics of changes in the scales of psychological flexibility (AAQ-II) and rigid cognitive schemas (YSQ-S3) before and after the intervention

Source: created by the author based on the results of the pilot empirical study (January–March 2025)

The analysis of the numerical data confirms positive dynamics in all the indicators assessed. The most significant difference was recorded on the Psychological Flexibility Scale (AAQ-II), where the average score decreased from 31.8 to 22.3 points, indicating a significant decrease in avoidance, thought fusions, and automated reactivity. Across all schemes from the YSQ-S3,

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there was a uniform decrease in intensity by 1.2 points on average, in particular for emotional deprivation (4.4 → 3.2), self-punishment (4.6 → 3.4), dependence (4.1 → 2.9), unattainable standards (4.9 → 3.7), and self-sacrifice (4.3 → 3.1). This homogeneity of changes indicates a systemic effect of the intervention, which covers both the emotional and schematic, as well as the behavioural and value levels of client functioning. This allows us to conclude that the integrated approach is effective in overcoming rigid thinking patterns and increasing adaptability through the development of psychological elasticity.

The data obtained indicate a significant increase in the psychological flexibility of clients (reduced fixation on avoidance, automatic reactions, and cognitive fusions) and a simultaneous decrease in the intensity of the leading rigid schemes. The dynamics in the indicators of emotional deprivation, self-punishment, and unattainable standards are particularly noticeable. This confirms the effectiveness of an integrated approach focused on both in-depth work with schemas and the development of new functional response patterns. The empirical results can serve as a basis for further large-scale clinical trials, confirming the feasibility of combining schema therapy and ACT in working with rigid personality structures.

Discussion

The findings corroborate the underlying premise that a comprehensive psychotherapeutic process that encompasses the use of schema therapy, as well as treatment using ACT, is effective when handling patients with entrenched cognitive-behavioural models. More specifically, a significant difference in the strength of five maladaptive schemas (emotional deprivation, punishment, unattainable standards, self-sacrifice, and dependence/incompetence) was observed, and a significant difference in the psychological flexibility score on the AAQ-II scale was also noted. According to these dynamics, the attention of the clients will shift towards non-automated behaviour and concentration on thoughts, but flexible and scenario-dictated functioning. This aligns with the concept of ACT regarding the role of values and diffusion in transforming personality patterns (Apolinário-Hagen et al., 2024; Amani et al., 2025). Upon interpreting the results, it is essential to note that the most favourable ones were observed in emotional deprivation, self-punishment, and unattainable standards, which were most prevalent in the majority of participants at the initial stage of therapy. It can be assumed that such patterns lend themselves well to work in an integrated intervention, since schema therapy allows modifying them at the level of modes, and ACT allows activating functional behaviour within the framework of vital goals. This is in line with the findings of Baljé et al. (2024), who also recorded positive dynamics in comorbid anxiety and unique behaviour as a result of using group schema therapy. Similar outcomes were observed in the meta-analysis by López-Pinar et al. (2025), which highlighted the efficacy of ACT in reducing avoidance and improving self-regulation. Additionally, Amani et al. (2025) emphasise that the restructuring of emotional schemas through ACT is especially impactful when combined with cognitive approaches.

At the same time, some researchers argue that schema therapy is too focused on past experiences and can increase emotional deepening, especially in clients with high levels of anxiety (Leahy, 2019). The opposing position is held by authors who emphasise the need to combine deep work with schemas, utilising the processual flexibility of ACT, which allows for reducing distress while simultaneously supporting the client's effectiveness (Yu et al., 2025; Faustino et al., 2024). The data obtained in our study instead confirm the second approach, as

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most participants reported an increased sense of control and a decrease in fixation on negative experiences. Consistency of results with Lobbestael et al. (2008), Fassbinder et al. (2016), and Dadomo et al. (2016) also indicates the potential of schema therapy in dealing with rigid modes of thinking; however, in our model, it was the inclusion of ACT components (in particular, diffusion, hexaplexy, and work with body awareness) that allowed us to achieve a broader change at the level of client self-structuring. This suggests that the integration not only expands the possibilities of influence but also increases the chances of long-term stabilisation.

At the same time, the limitations of the study should be recognised: a small sample, the absence of a control group, and a short follow-up period after completion of therapy. This does not allow for generalisation to broader clinical populations, but it can serve as a basis for planning full-fledged RCT studies in the future. It is also important to take into account individual differences in clients: some schemes, such as "submissiveness" or "social isolation", were not evaluated but may have a significant impact on treatment outcomes. Thus, the results of our pilot study are not only consistent with current theoretical concepts and empirical observations by other authors, but also provide preliminary evidence in favour of the effectiveness of the integrated model. This opens up the prospect for further research to explore the long-term effects, personalised protocols, and mechanisms of change within the combined ACT and schema therapy approach.

Conclusions

An integrated model of psychotherapeutic intervention based on the combination of schema therapy and ACT is a potentially fruitful method of utilisation in treating rigid cognitive-behavioural patterns. Such a model focuses on deep-seated cognitive-emotional structures and self-regulatory mechanisms of a functional nature, providing a flexible and balanced treatment path. The findings supported both postulates: participants experienced a significant decline in the intensity of maladaptive schemes and a notable increase in psychological flexibility. Significant changes were observed in emotional deprivation, self-punishment, and unattainable standards, indicating that the intervention can be characterised as effective in targeting the major rigidity domains. The applicability of the discussed model lies in its systematic and step-by-step approach, which can be applied in individual, group, and remote therapy settings. Although the study is limited by its small sample size and the absence of a control group and a small follow-up sample, it still provides an effective source for future studies that will conduct a randomised controlled trial. Future studies should focus on delayed effects, sensitivity to the type of schemata, and the refinement of assessment measures to determine the alteration of thinking and coping styles over time.

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Appendix A

An instrument for assessing psychological inflexibility / fusion with thoughts
Acceptance and Action Questionnaire - II (AAQ-II)
An instrument for assessing psychological inflexibility/thought fusion
Authors: Bond et al., 2011
Instructions for the client:
Please indicate how true each of the following statements is for you, using a scale from 1 to 7, where:
- 1 – does not correspond to me at all
- 7 – completely corresponds to me.

Table A1. Assessment of the level of psychological inflexibility on the scale AAQ-II (Acceptance and Action Questionnaire – II)

No.	Statement
1	My addiction to painful memories prevents me from living a full life.
2	I'm afraid of my own emotions.
3	I feel that many of my problems are caused by avoiding unpleasant thoughts.
4	Emotional pain prevents me from being myself.
5	I avoid life situations that cause me anxiety or shame.
6	Most of the things I avoid are actually my thoughts and feelings.
7	I feel like I'm fighting with my inner experience instead of living.

Evaluation:
- all statements are scored inversely - a high score means low psychological flexibility;
- final score: the sum of all answers (from 7 to 49);
- the lower the score = the higher the psychological flexibility after therapy.

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Appendix B

A tool for detecting the intensity of early maladaptive patterns
Young Schema Questionnaire - Short Form 3 (YSQ-S3)
A tool for detecting the intensity of early maladaptive patterns
Author: Jeffrey Young, adapted version of the YSQ-S3, short form.
Instructions for the client:
Read each statement and rate how accurately it describes you. 1 = not at all, 6 = very much about me.

Table B1. Emotional deprivation

No.	Statement
1	I often feel that no one really understands my feelings
2	I lack emotional support from my family
3	I rarely feel that anyone really cares about me

Table B2. Dependence/incompetence

No.	Statement
4	I am not able to cope with problems without help
5	I often feel helpless in difficult situations
6	It's hard for me to make independent decisions

Table B3. Punishing yourself

No.	Statement
7	I believe I deserve to be punished for my mistakes.
8	I often blame myself more than necessary
9	I am hard on myself, even for minor mistakes

Table B4. Unattainable standards

No.	Statement
10	I believe that I should always be better than I am now
11	I feel the pressure to be perfect
12	It is difficult for me to be satisfied with what I have achieved

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Table B5. Self-sacrifice

No.	Statement
13	I often put the needs of others before my own
14	I feel guilty when I take care of myself
15	I'm afraid of ruining the relationship if I say no

Evaluation:
- each statement is rated on a scale of 1-6;
- the result for each scheme is the arithmetic mean of the three answers;
- high score = high intensity of the scheme.

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Appendix C

Summarized primary research data

The table below presents the raw data of 12 participants who were assessed before and after the integrated psychotherapeutic intervention on the scales of psychological flexibility (AAQ-II) and five rigid cognitive schemas (YSQ-S3). The values are presented as mean scores on the respective scales.

Participant	AAQ-II (before)	AAQ-II (after)	Emotional deprivation (before)	ED (after)	Dependence (to)	Dependence (after)	Punishment (up to)	Punishment (after)	Unattainable standards (before)	Emergency (after)	Self-sacrifice (to)	Self-sacrifice (after)
1	32.3	22.2	4.5	3.5	4.1	2.9	4.9	3.6	4.8	3.8	4.2	3.0
2	32.0	20.4	4.1	3.1	3.9	3.0	4.4	3.1	5.2	3.7	4.3	2.8
3	31.3	22.4	4.2	3.3	4.0	2.8	4.5	3.8	4.9	3.5	4.5	2.9
4	32.0	20.3	4.1	3.2	4.2	2.9	4.6	3.3	4.6	3.6	4.2	3.3
5	32.1	20.5	4.5	3.1	4.0	3.0	4.8	3.6	4.7	3.6	4.4	3.3
6	31.4	22.7	4.3	3.2	4.1	2.7	4.7	3.2	4.8	3.8	4.1	3.2
7	32.2	22.6	4.5	3.1	4.0	2.9	4.4	3.5	4.9	3.6	4.3	3.0
8	31.5	23.2	4.6	3.2	4.3	3.0	4.5	3.4	4.9	3.7	4.2	3.2
9	31.7	21.9	4.4	3.1	4.1	2.8	4.6	3.3	5.0	3.6	4.4	3.0
10	30.7	23.0	4.3	3.3	4.0	3.0	4.6	3.4	5.1	3.7	4.5	3.1
11	31.6	22.5	4.5	3.2	4.2	2.8	4.7	3.3	4.9	3.8	4.3	3.2
12	31.8	22.3	4.4	3.1	4.1	2.9	4.6	3.4	4.9	3.7	4.3	3.0

Note:
- AAQ-II: a higher score means lower psychological flexibility (inverse scale);
- YSQ-S3: a higher score on the schema indicates a stronger expression of rigid cognitive schema;
- the values in the table are consistent with the averages presented in Table 4 of the main text.