Shedding light on schema modes: a clarification of the mode concept and its current research status

Jill Lobbestael*, Michiel van Vreeswijk** and Arnoud Arntz*

While the schema mode construct is one of the main concepts of schema-focused therapy (SFT) for personality disorders (Young, 1990; Young & Klosko, 1994; Young, Klosko, & Weishaar, 2003), the mode concept lacks clear theoretical and scientific embedding, and therapeutic guidelines about when to use modes in clinical practice are not always clear. Therefore, the current article aims at clarifying schema modes theoretically and by therapeutic vignettes. Modes are different aspects of the self that reflect the currently active cluster of cognitions, emotions and behaviour (Young et al., 2003). The different schema modes are presented, as well as mode conceptualisations for several personality disorders. The distinction between healthy and pathological modes is outlined, as well as the link with dissociation and the concept of mode switching. Furthermore, mode assessment and SFT is addressed, next to theoretical studies on schema modes. Whilst the recent progress in treatment possibilities and effectiveness of SFT is impressive, basic tests of the modes are limited. Finally, directions for further studies are suggested. (*Netherlands Journal of Psychology*, 63, 76-85.)

Keywords: Schema-focused therapy; schema modes; personality disorders; mode assessment

Schema-focused therapy (SFT) is becoming an increasingly popular and widespread variant of cognitive therapy for treating personality disorders (PDs). A study by Giesen-Bloo, et al. (2006)

* Department of Clinical Psychology Research, Maastricht University
** Delftland Mental Health Service, Outdoor Clinic, Location de Gravin, Delft
Correspondence to: Jill Lobbestael, Department of Clinical Psychology Research, Maastricht University, PO Box 616, NL 6200 MD Maastricht, E-mail: jill.lobbestael@dmkep.unimaas.nl.

demonstrated SFT to be superior to psycho-dynamically based transference-focused psychotherapy in reducing borderline personality disorder (BPD)-specific and general psychopathological dysfunction and in improving quality of life. Three main concepts are central in SFT. The first is that of early maladaptive schemas (EMSs), which are broadly defined as the unconditional and dysfunctional underlying beliefs about the self and one's relationship with others. EMSs are developed during childhood and serve to selectively filter incoming experiences such that schemas are extended and elaborated throughout an individual's lifetime. Behaviours are embedded

in the coping styles that form the second main feature in SFT. Young postulates that a person can maintain his/her EMSs by means of three coping methods: overcompensation (fight the schema as though the opposite were true), avoidance (avoid the schema being activated) and surrender (give in to the schema) (Young et al., 2003). Because of the close link of both EMSs and coping styles to basic cognitive theory constructs (Beck & Freeman, 1990; Beck, Freeman, & Davis, 2004) and the increasing number of studies targeting the theoretical underpinning of these constructs (see e.g. Ball & Cecero, 2001; Jovev & Jackson, 2004; Petrocelli, Glaser, Calhoun, & Campbell, 2001), EMSs and schema coping are concepts that are well known in clinical practice. However, most researchers, practitioners and patients are less acquainted with the third SFT concept, schema modes. The unfamiliarity with the concept of schema modes is due to the fact that it is a new and quite difficult construct that emphasises many elements. Therefore, the current article aims at clarifying the mode concept, both on a theoretical level as well as on a clinical level. By means of clinical vignettes the concept and how it is used in treatment is illustrated. Also, the current status of research on mode assessment and experimental studies is described, and recommendations for further studies are given.

From schemas to schema modes

While the schema approach proved to be a valuable model for treating many patients, schema assessment in patients with BPD posed an extra challenge because these patients recognise many different schemas, and several schemas can be active at the same time (in extreme cases of BPD as many as 15 schemata at once), making it difficult to pinpoint concrete therapy goals. Furthermore, patients with severe PDs can seem calm and in control most of the time, and all of the sudden burst into anger or become very sad. These rapid changes in behaviour and feelings, reflective of emotional instability, cannot be accounted for sufficiently by means of the EMS concept, since these schemas are conceptualised as trait constructs referring to stable underpinning of personality. Additionally, it appeared that certain schemas and coping responses were always triggered together. Young blended a number of these schemas and coping strategies together narrowing down the number of them, and refers to these sets of matching schemas and coping responses as schema modes (Bamber, 2004; Young et al., 2003). The standard definition of schema modes is: 'those schemas or schema operations – adaptive or maladaptive – that are currently active for an individual' (Young et al., 2003). This way, the introduction of modes into SFT does not imply the addition of a new content-related aspect, but merely pro-

vides a different unit of analysis, making schemas and coping features more manageable. While some modes are primarily composed of schemas, others mainly represent coping responses. Schema modes reflect the emotional and behavioural state at a given moment in time in an individual, and comprise thoughts, emotions and behaviours. Thus, in essence, there are two main differences between schemas and modes. First, schemas reflect a one-dimensional theme (e.g. Defectiveness), while modes are broader and reflect a combination of several schemas (e.g. the EMSs of Defectiveness and Emotional Deprivation are both part of the Lonely Child mode) and/or coping strategies. Second, schemas are stable, trait constructs, while modes alter depending on the situation one is in, and thus are state concepts that are strongly related to the present emotional state of the patient.

Frank, a 42-year-old postman with a major depression and an obsessive-compulsive personality disorder, tells his therapist about a situation where he helped a woman he liked and he thought liked him too. However, she sent him away after he had helped her without thanking him. This event triggered several schemas within the patient: Mistrust/Abuse because he thought the woman acted like this on purpose to humiliate him, Abandonment because he was convinced the woman abandoned him in favour of someone better, Defectiveness because he felt stupid because of how he had acted and Emotional Deprivation because he felt he did not get the emotional support he wanted from the woman. In response to this event, he called this woman a couple of hours later and begged her to go on a date with him (Overcompensation coping method), till the point came when she told him to get lost. The therapist and the patient are struggling with which schema or coping method is most important in this situation. They conclude that these schemas and coping response co-occurred in reaction to a strong feeling of abandonment, making this situation better to understand by clustering the schemas and coping response into the Abandoned and Abused Child mode. This is an example of a situation that triggers so many schemas in a patient that it becomes difficult to pinpoint the therapy goal. Consequently, in cases like these, it is more useful to conceptualise the elicited thoughts, behaviours and emotions in terms of a schema mode.

Modes and dissociation

Each person holds several modes within him/herself, so the modes can be seen as different aspects of one's personality. These different parts of the self can cause a patient to feel fragmented in that some facets of identity have not been fully integrated with the self. This does not imply that modes are entirely separated; although modes can operate independently of each other, a person does have access to several modes at a certain moment in time. Thus, they do not operate without awareness of each other. Therefore they cannot be seen as separate entities that are divided by amnestic barriers, as is for example thought to be the case in the dissociative identity disorder, in which it is assumed that certain aspects of personality are unaware of the presence of others and function as independent persons (Young et al., 2003).

> Jessica is a 25-year-old woman with a BPD who calls her therapist in a crisis. She started injuring herself and felt that something had to be done to prevent her from becoming suicidal. She had had a fight with her boyfriend because she was very angry when he refused to comfort her after she got scared when hearing of the death of a good friend, because he was too busy at that moment. As a first response, Jessica felt abandoned and vulnerable (Abandoned/Abused Child mode). Her despair grew and she began to view her boyfriend as no longer wanting her, which raised strong anger in her. She then got in a furious rage, in which she accused her boyfriend of rejecting her and not loving her, and yelled at him and hit him (Angry Child mode). She left the house in anger, telling her boyfriend that he had to move out of the house before she got back, and drove off in her car. While driving her car in a rather dangerous manner, she gradually realised how she had behaved towards her partner and started to feel guilty. When she returned home, her boyfriend had indeed left, triggering her abandonment feelings (Abandoned and Abused Child) after which she started to feel extremely guilty that she had sent him away and physically attacked him (Punishing Parent). She then started to cut herself because she felt she had to punish herself for her misbehaviour. When discussing this incident in the next therapy session, Jessica says the very diverse emotions she felt and behaviours she experienced made her confused about her self. This example illustrates the difficulty patients with very distinct modes can have in maintaining a unified sense of self. Note that she was able to remember those different emotional and behavioural states afterwards.

Different schema modes

Modes can be comprised of both healthy and pathological aspects, and are centred round specific, and very diverse themes. Maladaptive modes can reflect a sort of regression into intense emotional states experienced as a child, causing patients to appear very childish, while other modes can be reflective of an overdeveloped coping method, or the copying of behaviour displayed towards them by their parent that has eventually been internalised (Young et al., 2003).

Until now, 22 different schema modes have been identified. These include the ten central modes that are listed in Young et al. (2003), but also subdivisions of these modes that are hypothesised to characterise specific PDs. It is likely that more modes will be identified in the future, when mode conceptualisation of all PDs is completed. The 22 schema modes can be grouped into four main categories. The first group is that of child modes. These are innate and universal modes, meaning that all children are born with the potential to manifest them (Young et al., 2003). On the one hand, maladaptive variants of Child modes develop when certain core needs were not met in childhood, and can centre round themes of vulnerability, anger or lack of discipline. On the other hand, when childhood needs are adequately met, a person develops a Happy Child mode, representing the capacity to experience and express playful happiness. The second group reflects the dysfunctional coping modes that correspond directly to the three coping styles of Overcompensation, Avoidance and Surrender. The Dysfunctional Parent modes form the third mode group and reflect internalised behaviour of the parents towards the patient as a child. More specifically, children internalise frequently displayed behaviour of their parent towards them as a part of the self. The last mode group is that of the Healthy Adult mode which includes functional cognitions, thoughts and behaviours (Young et al., 2003). Detailed definitions of the 22 schema modes, and their division into the four central categories and associated themes are depicted in appendix A (adapted from Bernstein & Arntz, submitted for publication and Young et al., 2003).

Modes and personality disorders

Each person exhibits several characteristic schema modes, but some combinations appear typical for certain PDs. According to Young et al. (2003), the BPD is characterised by four primary maladaptive schema modes: (1) the Abandoned and Abused Child, which is not surprising given the high prevalence of childhood abuse in borderline patients, (2) the Angry Child that parallels the central place of excessive and misplaced

anger in the DSM-IV BPD criteria, and (3) the Punitive Parent mode that originates from the harshly punishing and rejecting family environment BPD patients often experienced (Young, 2005; Young et al., 2003). Most of the time, however, BPD patients find themselves in the (4) Detached Protector mode, providing them with the opportunity to emotionally shut off from the negative emotions caused by the other dysfunctional modes, and giving them a safe hiding place. Since patients seem quite at ease in this mode, therapists often confuse this Detached Protector mode state with the Healthy Adult mode, while in fact they are shutting off their emotions and avoid dealing with them (Young et al., 2003).

Although mode conceptualisation originated from the work with BPD, it is now applied to other diagnostic categories as well. The mode conceptualisation of antisocial PD (ASPD) greatly resembles that of BPD in that the Abandoned and Abused Child, Angry Child, Punitive Parent, and Detached Protector are also central to ASPD patients. This can be explained by the similarity of the diagnostic criteria of BPD and ASPD (Lobbestael, Arntz, & Sieswerda, 2005; Paris, 1997). However, Young postulates that ASPD patients display a fifth additional maladaptive schema mode: the Bully and Attack mode. Additionally, the Angry Protector mode, the Conning and Manipulative mode and the Predator mode are assumed to play a central role in antisocials high in psychopathy (Bernstein & Arntz, submitted for publication).

The third personality disorder that has been conceptualised in terms of schema modes is the narcissistic PD (NPD). Their default mode that dominates self-representation is that of the (1) Self-Aggrandiser. In order to deal with emotions of loneliness, NPD patients switch to the (2) Detached Self-Soother mode. Underneath the flamboyant representation, lies the (3) Lonely Child mode, which narcissists avoid activating in order to cover up their vulnerability (Young et al., 2003). Arntz and Bögels (2000) elaborated this model with the (4) Enraged Child mode, which narcissists switch to as a final defence to the eliciting of the inferior position of the Lonely Child, when external causes can be found that can be attacked and destroyed.

Recently, mode models for five other PDs have been proposed. Modes that are hypothesised to be central in avoidant PD are the Avoidant Protector (a variant of the Detached Protector in which avoidance is the prominent strategy), the Compliant Surrender, the Lonely Child, and the Critical Parent. The dependent PD is thought to be characterised by the Compliant Surrender, in combination with the Dependent Child, and the Critical Parent mode. Central for the obsessive-compulsive PD are the modes of the Critical Par-

ent, and the Lonely Child, while patients with paranoid PD are characterised by an Avoidant Protector and a Humiliated and Abused Child mode (a variant of the Abandoned and Abused Child mode). Both patients with obsessive-compulsive and paranoid personality disorder display the Overcontroller mode. The obsessive type uses order, repetition, or ritual (Perfectionistic Overcontroller), while the paranoid type attempts to locate and uncover a hidden (perceived) threat (Suspicious Overcontroller). To conclude, the histrionic patient has the mode of Attention and Approval Seeker, Undisciplined/Impulsive Child and the Ignored or Inferior Child.

To the best of our knowledge, only two studies have tried to test the mode conceptualisations of PDs in borderline and cluster C PDs (Arntz, Klokman, & Sieswerda, 2005) and borderline and antisocial PDs (Lobbestael, Arntz et al., 2005), as compared with healthy controls. Both studies found evidence that the hypothesised modes of the Abandoned and Abused Child, Angry Child, Detached Protector and Punitive Parent were specific for BPD. Antisocial patients displayed the same pattern of modes, and also demonstrated the highest level of Bully and Attack mode, although not significantly higher than the borderline patients.

> Elisabeth, a 33-year-old patient with a BPD, is staring with a glazed look in her eyes. When one of the patients in the therapy group asks her what is going on, she answers; 'Nothing' (Detached Protector mode). When other patients say that they do not believe Elisabeth, that it seems as if she is detached, she becomes angry and says; 'Oh just leave me alone. Nothing I do is right. I destroy everything. I do not deserve to live. I deserve a horrible death instead (Punishing Parent mode)' When the therapist says that it must be horrible to feel so bad about yourself, Elisabeth looks at him for a moment as if she wants to attack him, then it seems that she will give a cynical response, but seeing how the other group members are looking at her with interest, she starts to cry (Abandoned and Abused Child mode). This fragment describes how a patient switches between three modes in a short time span in response to reactions of the other group members and the therapist.

From normality to pathology

Schema modes are not unique markers of pathology; to a certain degree, everybody holds several modes. Rather than reflecting distinctive entities, modes of healthy people and patients differ in a gradual way on several dimensions.

Firstly, healthy persons have recognisable modes but their feeling of a unified sense remains intact, while dissociation between modes increases with the severity of pathology (Young et al., 2003). Secondly, healthy people are able to simultaneously experience more than one mode at the same time and in this way blend modes together. Movement to another mode often occurs gradually and seamlessly. In contrast, patients with severe PDs display more sudden shifts between pure modes and experience only one mode at a time, for example when anger takes over the patient's personality (Bamber, 2004; Young et al., 2003). Furthermore, healthy persons acknowledge their modes more easily than patients, and their modes are more adaptive, mild and flexible. So while patients display a higher number and intensity of modes, they do not generally display *different* modes than healthy people (Young et al., 2003). This way SFT provides a less stigmatised view of pathology; it contains the message that everybody has different sides to them but in severe pathology the balance between these modes is lost.

Mode switching

While a person is characterised by several schema modes, at a given moment in time, only one mode is predominant and determines the current behaviour of patients with severe pathology. This dominant mode shuts off the other modes. Predominant modes can become dormant and visa versa. This altering of modes is often experienced as a sudden and abrupt shift and is referred to as mode switching or 'flipping' (Bamber, 2004; Young et al., 2003). This phenomenon explains the abrupt changes in thoughts, feelings and behaviour often observed in BPD patients. In contrast to most patients with PDs who are often trapped in a rigid style (e.g. obsessive-compulsive patients), borderline patients are often in a state of flux, with rapid altering in displayed behaviour and emotions. When switching into a specific mode, this mode appears to overshadow other modes that seem to disappear. Schema modes can elicit one another, and appear in varying strength and order, without the patient having control of this. Modes are triggered in reaction to changes in the environment or internal cues, linked to life situations to which people are oversensitive or which push their 'emotional buttons'. In order words, depending on the situation, a completely different side of patients can be seen (van Genderen & Arntz, 2005; Young, 1990). This way, the mode model provides a valuable explanation why, despite severe pathology, patients with for instance antisocial PD can appear so normal; at that moment there are probably no cues causing them to flip to aggressive modes, for example.

Participants of the study by Arntz et al. (2005) filled out a state version of the SMI before and after a stress induction by means of a BPD-specific emotional movie fragment. Results demonstrated that the Detached Protector mode increased significantly more in the BPD group as compared with both control groups of cluster C PDs and healthy participants. Studies like these that manipulate emotions in the laboratory raise the likelihood of assessing true changes in emotions, rather than merely on a hypothetical or cognitive level, and in a way turn 'cold' cognitions into 'hot' ones. This makes emotion inductions very valuable for gathering information on how patients would react in daily life to emotions, and provide the opportunity of studying the effect of changing environmental stimuli on mode switching.

Jack, a 36-year-old patient with antisocial PD who has been in prison for killing his neighbour after a fight in which he felt offended, is receiving therapy for partner-relation problems. Jack comes to the fourth session, well dressed and speaking in a very friendly and polite manner to the therapist. When the therapist asks how he is doing and how his wife is, Jack avoids the question. The therapist, surprised at his avoidance, confronts him: 'Jack, I believe you were telling me last time that you had a quarrel with your wife. Now I am asking how the two of you are getting along, you seem to be avoiding my question.' It appears that this remark pushes one of Jack's emotional buttons as Jack suddenly snaps at the therapist to mind his own business. This patient, who first seemed so friendly, suddenly becomes disproportionally furious and threatening.

Assessment of modes

Dysfunctionality of modes can be assessed in two ways: by mapping their frequency and their intensity. In other words; a mode can be problematic when it dominates the person most of the time, or when it pops up extremely intensely. In general, there are three ways of tracing schema modes in patients. First, by probing patients about problematic situations and reframing their displayed behaviour, thoughts and feelings in mode terms on a cognitive level. Secondly, modes can be retrieved by means of experiential exercises in which patients are guided back to the past. While these two methods can only be applied in therapy, the third method includes self-report by means of questionnaires, and is also suitable for research purposes. In practice, it is advisable to combine these three assessment methods. Until now, there are two instruments available for assessing modes: the Young Atkin-

son Mode Inventory (YAMI, Young, Atkinson, Arntz, Engels, & Weishaar, 2005) and the Schema Mode Inventory-revised (SMI-r, Lobbestael, van Vreeswijk, Arntz, Spinhoven, & 't Hoen, 2005). The YAMI assesses the presence of the ten central modes as proposed by Young on frequency by means of 187 items. The SMI-r measures 16 schema modes (marked with an asterisk in the mode overview) by means of 270 items that have to be scored on a six-point Likert scale measuring frequency and ranging from 'never or hardly ever' to 'always'. All items of the YAMI are imbedded in the SMI-r, and additional items of the SMI-r are based on the SMI (Klokman, Arntz, & Sieswerda, 2001), on suggestions by Beck et al., (2004) and Young et al., (2003) and clinical observations. The fact that the SMI-r assesses 16 schema modes has the incremental quality of providing information on all disorder specific modes, and increases clinical relevance. Recently, we also developed a short version of the SMI-r in order to make mode assessment more practical for both clinical practice and research purposes. This short SMI-r contains 125 items. In the selection process of items that loaded uniquely on the different subscales, not enough unique items could be selected for two of the modes (the Lonely Child and the Overcontroller). Consequently, this short SMI-r measures the presence of 14 modes. Currently, the psychometric properties of the Dutch version of the SMI-r are being studied by Lobbestael, van Vreeswijk, Arntz and Spinhoven (2007) in a large population of both clinical and non-clinical participants. Preliminary data of this study provide support for the 16-factor structure of the long version of the SMI-r and for a 14-factor structure of the short SMI-r by means of confirmatory factor analyses. Furthermore, all subscales possessed good to very good internal reliabilities and test-retest reliabilities of all subscales.

Schema mode therapy

The mode model provides a valuable therapeutic framework for the understanding of personality pathology. This is especially the case because by means of modes, the variety of complaints and dysfunctional beliefs displayed by patients with complex PDs can be clustered together, which makes it easier to understand them and work therapeutically with them, and because the switching between the modes provides a valuable explanation for the rapid changes in cognitive-emotional-behavioural states seen in these patients. The goal of therapy is to strengthen the healthy sides of patients, and weaken the strength and impact of the maladaptive modes. Therapists help patients to flip from dysfunctional to healthy modes. Schema-focused therapy and schema mode therapy do not reflect two separate therapies, rather mode work is seen as an advanced component of schema work,

which can be used whenever the therapist feels working with schemas alone is inadequate (Bamber, 2004).

Schema-focused therapy blends various forms of psychotherapy such as cognitive behavioural therapy, gestalt and interpersonal therapy. When maladaptive modes are less prominent and healthy modes are in control most of the time, cognitive and behavioural techniques such as multi-dimensional evaluation, pie charts, schemas and mode diaries, positive logbooks, flashcards, role plays and behavioural experiments can be used effectively. However, when maladaptive modes become more prominent, experimental techniques such as (historical) role plays and imagination (see for example Arntz & Weertman, 1999; van Genderen & Arntz, 2005; Young et al., 2003) are indicated. Art techniques can also be added and can give patients the opportunity to express what they are not able to say in words, or help them to get a grip on images of safety, for example by hanging drawings of a safe haven in their home (see also Haeyen, 2006). Lately, experimental techniques as used in mindfulness-based cognitive therapy for depression (Segal, Williams, & Teasdale, 2002) have also been adapted and enhanced to be used in SFT (van Vreeswijk, Broersen, & Schurink, 2006). Mindfulness techniques can make patients become aware of this mode triggering in which they automatically respond to a situation or emotion. Patients learn to view emotions, schemas and modes as (dark) clouds that come and go and which they have to accept in order to gain control. In this way the emotional affect tone becomes less severe, different coping styles can come to mind and it becomes easier to make a thoughtful decision and give an adequate healthy response.

> Francine is a 26-year-old woman with dysthymia, social anxiety disorder and an avoidant PD. One day she did not do her therapy homework and as she comes into the therapy room she immediately apologises to the therapist. When the patient and therapist are exploring this response of Compliant Surrender and its function to avoid confrontation, Francine makes a harsh remark to herself for failing to do her homework. She than switches into the Detached Protector, looking away from the therapist and not responding to his question. When the therapist asks Francine if she can come up with a memory from her childhood where she felt the same way as she feels now, the patient makes contact again by mentioning a memory in which her mother is yelling at her for not doing well enough at school. The therapist asks Francine to think of that situation and to introduce the Healthy Adult of Francine into that memory, who is listening to what little Francine needs

and to speak up for her against her mother. While hesitating at first, there is some relief at the end when Francine reflects on the exercise. For the first time in her life she has stood up for herself, not accepting the punitive voice of her parent.

Critical evaluation of modes and recommendations for further studies

A first critical point with respect to schema modes is when looking at the large number of modes that are and that will be identified, the question arises what the ultimate goal of mode conceptualisation should be. Is this to describe the specific modes of all PDs in all their nuances, or to provide a limited set of basic modes that can be used to understand PDs in more general terms. Clearly, the first option holds the risk of forming a never-ending list of modes. Therefore, perhaps it is sufficient to determine a set of modes that are most prevalent for the most severe PDs, but experience so far indicates that clinicians and researchers will continue to 'invite' more modes because they feel these modes are required to understand specific types of personalities.

A recent study by Lobbestael, van Vreeswijk and Arntz (2007) assessed which modes characterise the different PDs by means of path analyses and found BPD to be associated with nine schema modes. Although these comprised all modes that were a priori hypothesised to be central to BPD, several additional modes appeared to characterise BPD as well. This high number of modes central to BPD is quite surprising given the fact that the mode concept was developed because especially borderline patients recognised so many schemas that it was difficult to pinpoint specific therapy goals. Thus, modes were developed to provide a more comprehensive clustering of these schemas and coping methods, narrowing down the number of them. Since it appears that borderline patients are also characterised by so many modes, the question arises whether the mode concept indeed simplifies the cognitive conceptualisation of borderline patients.

A third critical point concerns the fact that modes are composed of three levels: cognitions, emotions and behaviours. Mode theory presumes that these three levels are so consistent with each other that they change synchronically. So when a person flips to another schema mode, this causes equal activation of that mode's cognitions, emotions and behaviours. This assumption, however, has never been empirically tested. Research targeting anger reactivity, for example, has demonstrated that changes in different anger-related domains are not synchronic. A study by Lobbestael, Arntz and Wiers (in press), for example, demonstrated low correlations between self-reported emotions and physiological indices. If discrepancies like these already occur in a single emotion like anger, there is a possibility that this will also be the case for complex constructs such as schema modes.

The paucity of experimental studies on this topic illustrates that research on schema modes is still in its infancy. Clearly, further studies are warranted. In the first place, to underpin existing mode conceptualisations of borderline, antisocial and narcissistic PDs. Secondly, explorative research in other personality disordered groups is necessary in order to provide insight on modes characterising these disorders, and to assist in the development and conceptualisation of new submodes that are specific for these disorders. Thirdly, there is a need for hard measures on schema modes, providing insight into how modes are associated with displayed behaviour and emotional responses. Mood inductions are the techniques par excellence to answer this validity research question. Finally, in light of therapeutic effectiveness, there is a need for replication of large-scale studies as that by Giesen-Bloo et al. (2006), and implementation studies of SFT (as is currently being performed by Nadort, 2006). Also, research into therapy effectiveness of SFT for other PDs besides borderline (currently being conducted by Bamelis and Arntz, 2006, for the paranoid, histrionic, narcissistic, dependent, avoidant and obsessive-compulsive PDs) and for SFT group therapy (see van Vreeswijk & Broersen, 2006, for protocol) is warranted.

References

Arntz, A., & Bögels, S. (2000). *Schemagerichte cognitieve therapie voor persoonlijkheidsstoornissen*. [Schema-focused cognitive therapy for personality disorders]. Houten: Bohn Stafleu van Loghum.

Arntz, A., Klokman, J., & Sieswerda, S. (2005). An experimental test of the schema mode model of borderline personality disorder. *Journal of Behavior Therapy and Experimental Psychiatry*, *36*, 226-239.

Arntz, A., & Weertman, A. (1999). Treatment of childhood memories: Theory and practice. *Behaviour Research and Therapy*, *37*, 715-740.

Ball, S. A., & Cecero, J. J. (2001). Addicted patients with personality disorders: Traits, schemas, and

presenting problems. *Journal of Personality Disorders, 15,* 72-83.

Bamber, M. (2004). 'The good, the bad and defenceless Jimmy'- A single case study of schema mode therapy. *Clinical Psychology and Psychotherapy, 11,* 425-438.

Bamelis, L., & Arntz, A. (2006). Psychological treatment of personality disorders: A multi-centered randomized controlled trial on the (cost-) effectiveness of Schema-Focussed Therapy. Manuscript in preparation.

Beck, A., & Freeman, A. (1990). *Cognitive therapy for personality disorders.* New York: The Guildford Press.

Beck, A., Freeman, A., & Davis, D. (2004). *Cognitive Therapy of Personality Disorders.* Second edition. New York: The Guilford Press.

Bernstein, D. P., & Arntz, A. (Submitted for publication). Adapting and implementing Schema Focused Therapy in forensic settings: Theoretical model and guidelines for best clinical practice.

Giesen-Bloo, J., van Dyck, R., Spinhoven, P., van Tilburg, W., Dirksen, C., van Asselt, T., et al. (2006). Outpatient psychotherapy for borderline personality disorder. Randomized trial of Schema-Focused Therapy versus Transference-Focused Psychotherapy. *Archives of General Psychiatry, 63,* 649-658.

Haeyen, S. (2006). Imaginatie in beeldende therapie. Een schemagerichte benadering. [Imagination in imaging therapy: A schema focussed approach]. *Tijdschrift voor Vaktherapie, 1,* 3-8.

Jovev, M., & Jackson, H.J. (2004). Early maladaptive schemas in personality disordered individuals. *Journal of Personality Disorders, 18(5),* 467-478.

Klokman, J., Arntz, A., & Sieswerda, S. (2001). The schema mode questionnaire (state and trait version), internal document. Maastricht: Maastricht University.

Lobbestael, J., Arntz, A., & Sieswerda, S. (2005). Schema modes and childhood abuse in borderline and antisocial personality disorders. *Journal of Behavior Therapy and Experimental Psychiatry, 36,* 240-253.

Lobbestael, J., van Vreeswijk, M., Arntz, A., & Spinhoven, P. (2006). The reliability and validity of the Schema Mode Inventory-revised (SMI-r). Manuscript in preparation.

Lobbestael, J., van Vreeswijk, M., Arntz, A., Spinhoven, P., & 't Hoen, T. (2005). The Schema Mode Inventory-revised. Maastricht: Maastricht University.

Lobbestael, J., van Vreeswijk, M. F., & Arntz, A. (2007). Schema modes in axis I and axis II patients and normal controls. *Manuscript in preparation.*

Lobbestael, J., Arntz, A. & Wiers, R. (2007). How to push someone's buttons: A comparison of four anger induction methods. *Cognition and Emotion,* [in press}.

Nadort, M. (2006). Implementation of out-patient schema-focused therapy for borderline personality disorder in regular psychiatry. Manuscript in preparation.

Paris, J. (1997). Antisocial and borderline personality disorders: two separate diagnoses or two aspects of the same psychopathology? *Comprehensive Psychiatry, 38,* 273-242.

Petrocelli, J.V., Glaser, B.A., Calhoun, G.B., & Campbell, L.F. (2001). Early Maladaptive Schemas of personality disorder subtypes. *Journal of Personality Disorders, 15,* 546-559.

Segal, Z., Williams, J., & Teasdale, J. (2002). *Mindfulness-Based Cognitive Therapy for depression. A new approach to preventing relapse.* New York: The Guilford Press.

van Genderen, H., & Arntz, A. (2005). *Schemagerichte cognitieve therapie* [Schema-focused cognitive therapy]. Amsterdam: Uitgeverij Nieuwezijds.

van Vreeswijk, M., Broersen, J., & Schurink, G. (2006). *Werkboek voor behandelmodule schema en modi aandachtsgerichte training eendaagse schemagerichte dagbehandeling* [Workbook for treatment module schema and schema focussed therapy training one-day schema-focused therapy]. Delft: GGZ Delfland.

van Vreeswijk, M. F., & Broersen, J. (2006). *Schemagerichte therapie in groepen* [Schema-focused therapy in groups]. Houten: Bohn Stafleu van Loghum.

Young, J. (2005). Schema-focused cognitive therapy and the case of Ms. S. *Journal of Psychotherapy Integration, 15,* 115-126.

Young, J., Atkinson, T., Arntz, A., Engels, & Weishaar, M. (2005). *The Young Atkinson Mode Inventory (YAMI-PM, 1B).* New York: Schema Therapy Institute.

Young, J.E. (1990). *Cognitive therapy for personality disorders: A schema-focused approach.* Sarasto: Professional Resource Exchange, Inc.

Young, J.E., & Klosko, J. (1994). *Reinventing your life.* New York: Plume.

Young, J.E., Klosko, J., & Weishaar, M.E. (2003). *Schema therapy: A practitioner's guide.* New York: Guilford.

Appendix A: List of the 22 schema modes

Child modes

Vulnerability

Lonely Child*
Feels like a lonely child that is valued only insofar as (s)he can aggrandise his/her parents. Because the most important emotional needs of the child have generally not been met, the patient usually feels empty, alone, socially unacceptable, undeserving of love, unloved and unlovable.

Abandoned and Abused Child*
Feels the enormous emotional pain and fear of abandonment, which has a direct link with the abuse history. Has the affect of a lost child: sad, frightened, vulnerable, defenceless, hopeless, needy, victimised, worthless and lost. Patients appear fragile and childlike. They feel helpless and utterly alone and are obsessed with finding a parent figure who will take care of them.
  Humiliated/Inferior Child. A subform of the Abandoned and Abused Child mode, in which patients experience humiliation and inferiority related to childhood experiences within and outside the family.

Dependent Child
Feels incapable and overwhelmed by adult responsibilities. Shows strong regressive tendencies and wants to be taken care of. Related to the lack of development of autonomy and self-reliance, often caused by authoritarian upbringing.

Anger

Angry Child*
Feels intensely angry, enraged, infuriated, frustrated or impatient, because the core emotional (or physical) needs of the vulnerable child are not being met. They vent their suppressed anger in inappropriate ways. May make demands that seem entitled or spoiled and that alienate others.

Enraged Child*
Experiences intense feelings of anger that result in hurting or damaging people or objects. The displayed anger is out of control, and has the goal of destroying the aggressor, sometimes literally. Has the affect of an enraged or uncontrollable child, screaming or acting out impulsively to an (alleged) perpetrator.

Lack of discipline

Impulsive Child*
Acts on non-core desires or impulses from moment to moment in a selfish or uncontrolled manner to get his or her own way, without regard to possible consequences for the self or others. Often has difficulty delaying short-time gratification and may appear 'spoiled'.

Undisciplined Child*
Cannot force him/herself to finish routine or boring tasks, gets quickly frustrated and soon gives up.

Happiness

Happy Child*
Feels at peace because core emotional needs are currently met. Feels loved, contented, connected, satisfied, fulfilled, protected, praised, worthwhile, nurtured, guided, understood, validated, self-confident, competent, appropriately autonomous or self-reliant, safe, resilient, strong, in control, adaptable, optimistic and spontaneous.

Maladaptive coping modes

Surrender

Compliant Surrender*
Acts in a passive, subservient, submissive, reassurance-seeking, or self-deprecating way towards others out of fear of conflict or rejection. Passively allows him/herself to be mistreated, or does not take steps to get healthy needs met. Selects people or engages in other behaviour that directly maintains the self-defeating schema-driven pattern.

Avoidance

Detached Protector*
Withdraws psychologically from the pain of the schemas by emotionally detaching. The patient shuts off all emotions, disconnects from others and rejects their help, and functions in an almost robotic manner. Signs and symptoms include depersonalisation, emptiness, boredom, substance abuse, bingeing, self-mutilation, psychosomatic complaints and 'blankness'.

Detached Self-Soother*
Shut off their emotions by engaging in activities that will somehow soothe, stimulate or distract them from feeling. These behaviours are usually undertaken in an addictive or compulsive way, and can include workaholism, gambling, dangerous sports, promiscuous sex, or drug abuse.

---

* These modes are enlisted in the Schema-Mode Inventory-Revised (Lobbestael, van Vreeswijk et al., 2005).

Another group of patients compulsively engage in solitary interests that are more self-soothing than self-stimulating, such as playing computer games, overeating, watching television, or fantasising.

Angry Protector
Uses a 'wall of anger' to protect him/herself from others who are perceived as threatening and keeps others at a safe distance through displays of anger.

Overcompensation

*Self-Aggrandiser**
Behave in an entitled, competitive, grandiose, abusive, or status-seeking way in order to have whatever they want. They are almost completely self-absorbed, and show little empathy for the needs or feelings of others. They demonstrate superiority and expect to be treated as special and do not believe they should have to follow the rules that apply to everyone else. They crave for admiration and frequently brag or behave in a self-aggrandising manner to inflate their sense of self.

*Overcontroller**
Attempts to protect him/herself from a perceived or real threat by focussing attention, ruminating, and exercising extreme control. Two subforms can be distinguished:
   Perfectionistic Overcontroller. Focuses on perfectionism to attain control and prevent misfortune and criticism.
   Suspicious Overcontroller. Focuses on vigilance, scanning other people for signs of malevolence, and controls others' behaviour out of suspiciousness.

*Bully and Attack**
Directly harms other people in a controlled and strategic way emotionally, physically, sexually, verbally, or through antisocial or criminal acts. The motivation may be to overcompensate for or prevent abuse or humiliation. Has sadistic properties.

Conning and Manipulative mode
Cons, lies, or manipulates in a manner designed to achieve a specific goal, which either involves victimising others or escaping punishment.

Predator mode
Focuses on eliminating a threat, rival, obstacle, or enemy in a cold, ruthless, and calculating manner.

Attention and Approval Seeker
Tries to get other people's attention and approval by extravagant, inappropriate, and exaggerated behaviour. Usually compensates for underlying loneliness.

Maladaptive Parent modes

*Punitive Parent**
This is the internalising voice of the parent, criticising and punishing the patient. They become angry with themselves and feel that they deserve punishment for having or showing normal needs that their parents did not allow them to express. The tone of this mode is harsh, critical, and unforgiving. Signs and symptoms include self-loathing, self-criticism, self-denial, self-mutilation, suicidal fantasies, and self-destructive behaviour.

*Demanding/Critical Parent**
Continually pushes and pressures the child to meet excessively high standards. Feels that the 'right' way to be is to be perfect or achieve at a very high level, to keep everything in order, to strive for high status, to be humble, to put other needs before one's own or to be efficient or avoid wasting time. The person feels that it is wrong to express feelings or to act spontaneously.

Healthy Adult mode

This mode performs appropriate adult functions such as working, parenting, taking responsibility, and committing. Pursues pleasurable adult activities such as sex, intellectual, esthetical, and cultural interests, health maintenance, and athletic activities.