Understanding psychological problems in terms of schemas and schema modes

–

A guide to conceptualization and treatment planning in schema therapy

David Edwards

Certified as a Schema Therapist, supervisor and trainer Individual and Couple) by the International Society of Schema Therapy

www.schematherapysouthafrica.co.za

Updated 15th June, 2019

Schema therapy offers a comprehensive approach to addressing longstanding psychological difficulties. It is drawn from many of the discoveries about what is helpful in psychotherapy that have been made over the past 100 years or so. It is an integrative approach to therapy developed by Jeffrey Young. He began teaching trainees how to do schema therapy in the 1980s, and in due course published descriptions of the approach for clinicians (Young, 1990; Young, Klosko and Weishaar, 2002) and for clients (Young & Klosko, 1994). Since then, schema therapy has been expanded through contributions by researchers and practitioners from many countries. This document summarizes some of the important aspects of this approach to assessment and therapy. For more resources visit my website at http://www.schematherapysouthafrica.co.za/ and the dedicated page on schema therapy: http://www.schematherapysouthafrica.co.za/schema-therapy/ where there are links to others sites on schema therapy. See also the books listed below or look at the more comprehensive list at http://www.schematherapysouthafrica.co.za/wp-content/uploads/2015/05/STISA-BOOKS-ON-SCHEMA-THERAPY2.pdf

Early maladaptive schemas

Early maladaptive schemas (EMSs) are longstanding patterns of psychological response that govern how we perceive the world, how we understand what is happening to us, what we feel and how we behave. They usually have their origins in infancy and early childhood and may even be set up before we are born (for example, if a traumatic event happened to our mother while she was pregnant). Six features of EMSs are identified by Young et al. (2003, p. 7). An EMS is...

- a broad, pervasive theme or pattern ...
- comprised of memories, emotions, cognitions, and bodily sensations ...
- a regard of oneself and one's relationships with others...
- developed during childhood or adolescence ...

- elaborated throughout one's lifetime, and
- dysfunctional to a significant degree.

A consequence of EMSs is that we behave in ways which are self-defeating or even self-destructive. These *schema driven behaviours* may be at the root of the emotional distress or problematic behaviours that lead a person to seek psychotherapy. EMSs are automatic and habitual and typically we do not realize the impact they have on our relationships and our approach to work and other aspects of life. We usually experience them as a fundamental part of us, something that feels like part of our personality or identity. For this reason, even when we recognize that they are problematic, we may feel helpless about changing them. The good news is, though, that these are usually learned patterns and schema therapy may enable us to change them.

Maladaptive schemas are responses to unmet needs

As infants and children, humans are vulnerable and helpless, and in order to develop in a psychologically healthy way, certain basic needs must be met. When basic needs are unmet, normal, healthy psychological development goes wrong and gives rise to EMSs that can continue to cause problems throughout life if they are not addressed. The needs of the normal infant and child are summarized below, with comments on the kinds of conditions under which they might not be met.

1. The need for safety and stability. This need may not be met where children are born into unsafe situations: for example, into times of natural disasters (earthquake, tsunamis), or into neighbourhoods or families where there is endemic violence.

2. The need for a secure, loving, and reliable bond with one or more caregivers. This need may not be met if the mother or main caregiver is not a warm, loving person who enjoys giving maternal care, or where she becomes unavailable through illness, depression, or economic hardship, or if she is emotionally unstable or unpredictable, or in a family where there is abuse and violence.

3. The need to be supported over the course of growing up, in moving from helplessness and dependence to a sense of competence (to function in the world), autonomy (ability to make one's own choices). This need may not be met where need 1 is not met and children feel overwhelmed and unsafe in the world. Similarly, it may not be met where caregivers fail to meet need 2 and fail to give consistent loving support to children as they venture out into the world and learn how it works. It will also not be met where caregivers are overprotective or are attached to having children who are dependent and helpless and have difficulty letting them grow up and become independent.

4. The need to find appropriate expression for emotions and needs in a way that leads to needs being met. As children grow, if they have the right kind of loving support, they learn to identify and express their feelings and needs in appropriate ways.

5. The need to learn how to flexibly manage and control one's emotional and behavioural reactions. This need may not be met when the need for safety and stability is not met, as children may experience such extreme emotions that it is beyond their capacity to modulate them. This need may not be met when the need for a stable loving relationship is not met, since learning to manage one's emotions takes place in the interaction with a warm loving caregiver. Where parents are harsh and punitive, children may internalize their punitive voices as a means of maintaining self-control.

6. The need to express oneself spontaneously, playfully and creatively. Playfulness and spontaneity are normal features of human (and animal) behaviour, and with development, mature into warmth and creativity. When these aspects of behaviour are neglected or actively discouraged or punished, individuals may lose their capacity for spontaneity and playfulness.

There is considerable evidence that these needs are universal, and that, as Young suggests, "a psychologically healthy individual is one who can adaptively get these core emotional needs met." Once EMSs form as a result of unmet needs, they have the perverse effect of making it difficult for those unmet needs to be met in the future. It is the aim of schema therapy to help people identify their schemas, to understand how these relate to their unmet needs, and to help them find adaptive ways to get these needs met in their current lives.

How early maladaptive schemas develop

Young, Klosko and Weishaar (2003) describe how early life experiences give rise to EMSs:

> "Toxic childhood experiences are the primary origin of early maladaptive schemas. The schemas that develop earliest and are the strongest typically originate in the nuclear family. To a large extent, the dynamics of a child's family are the dynamics of that child's entire early world. When patients find themselves in adult situations that activate their early maladaptive schemas, what they usually are experiencing is a drama from their childhood, usually with a parent. Other influences become increasingly important as the child matures, such as peers, school, groups in the community, and the surrounding culture, and may lead to the development of schemas. However, schemas developed later are generally not as pervasive or as powerful."

These authors suggest that there are four kinds of experience which give rise to EMSs:

1. *Toxic frustration of needs* occurs when the child's basic needs for a stable loving relationship and consistent care are not met.
2. *Traumatization* occurs when the child is harmed or victimized or exposed to traumatic situations such as natural disasters.
3. *Overindulgence and overprotectiveness* on the part of parents or caretakers prevent children from developing autonomy or appropriate self-control.
4. *Internalization of or identification with significant others* results in children taking on the thoughts, feelings, experiences, and behaviors of their parents or caretakers. For example, where a parent is punitive and critical, the child may become self-punitive and self-critical.

The 18 early maladaptive schemas and the YSQ

Clinical experience over several decades on the part of Young and his colleagues working with the schema therapy model has led to the development of a list of 18 early maladaptive schemas. This list (see appendix A) can be helpful, because each of these schemas is common and frequently contributes to the kinds of problems that lead people to seek psychotherapy. In helping you do identify the

schemas which are affecting you and which may be contributing to your current difficulties, the therapist will use a combination of sources of information. These include:

1. Information about your life history, including the circumstances of your birth and childhood, and the nature of relationships in your family.
2. Information about the kinds of everyday events that become problematic for you in your relationships and at work.
3. Information about other kinds of events that may trigger emotional distress (scenes from movies, items on news bulletins).
4. The Young Schema Questionnaire (YSQ), which is a self-report inventory with questions which tap each of the 18 schemas.

Schema processes

Schemas are not all equally active all the time. A complex set of processes determines which ones are active, and how we deal with them once they are active. These processes, themselves, are mostly automatic and outside of conscious control, so that often we may have very limited awareness of how they affect us. As a result, we are often puzzled by our own reactions, which may take the form of gradual or sudden shifts in mood or feeling, or behaviour or repeated behaviour which is obviously self-defeating or self-destructive. An analysis of schema processes helps us understand what underlies these experiences.

Schema triggering

Schemas may lie dormant until triggered by particular events or situations. For example, in relationships, a critical or dismissive remark from a friend or intimate partner may trigger schemas associated with rejection, abandonment, or abuse. Hearing about an accident or misfortune may trigger a schema associated with lack of safety or security. A disappointment or lack of achievement may trigger schemas associated with defectiveness, failure, or pessimism. A schema can be triggered by watching a scene from movie or reading a story in a magazine that is thematically related to the schema. Activation of a schema that is usually dormant can trigger a sudden rush of intense and confusing feelings. Other schemas present themselves less intensely. However, once a schema is active, it strongly shapes our patterns of perception, interpretation, feeling and behaviour.

When faced with a threat, there are three characteristic patterns of response which are found in humans and animals. These are the three Fs: *flight*, *fight* and *freeze*. Thus, if an animal is attacked by a predator it can try to escape (*flight*), try to fight back (fight), or go limp and play dead (*freeze*). These three kinds of response can be seen in the way people respond to cope with the triggering of schemas.

Schema surrender

Sometimes we simply experience the schema as it is, with its associated emotions and ways of thinking and behaving. For example, a person with an emotional deprivation schema may feel lonely, unloved, and unlovable and wonder if they will ever have an experience of loving relationship, or whether they are incapable of it. We call this *surrendering to the schema*. It feels as if it is our identity — that the

beliefs associated feel true, and we feel trapped in the unpleasant feelings associated with it. We don't do anything active to make the situation better. This can be thought of as an example of a *freeze* response.

Schema surrender can be self-perpetuating in two ways. First, the schema biases our interpretation of events. This is called *cognitive distortion*. For example, when individuals are surrendered to an emotional deprivation schema, they may simply not notice or they may discount any warm or loving behaviour directed at them. Second, the way the person behaves under the influence of the schema may negatively affect how others relate to them. This is called *self-defeating behaviour*. For example, individuals who they feel unloved and uncared for may come across as withdrawn and cold and alienate others who might otherwise have reached out to them.

Schema avoidance

Because schemas are associated with emotionally painful states, individuals actively avoid situations that might trigger them. A person with an abandonment schema may avoid getting emotionally close to anyone at all due to the intense pain that any separation or break in the relationship might cause. A person with an emotional deprivation schema may also avoid meaningful relationships due to these activating the pain of deprivation when the other person does not perfectly meet their needs. People with a failure schema may avoid striving to achieve anything of significance as a way of ensuring that they do not fail and, thus, do not activate the failure schema. This can be seen as an example of a *flight* response.

Avoidance can take three main forms: behavioural (actively avoiding contact with particular places, people or situations that might trigger a schema), cognitive (actively avoiding thinking about things that might trigger a schema) and emotional (shutting down emotionally when a schema has been triggered to avoid having to experience the associated pain). These may work up to a point, but a high price is paid. First, avoidance does not change the underlying schemas at all. They remain hidden and can be triggered if avoidance does not work. Second, avoidances are very limiting, and often self-defeating. They reduce an individual's quality of life and opportunities for engaging in potentially meaningful activities.

Schema overcompensation

When they overcompensate, individuals adopt strategies that contradict the schema to such an extent that it becomes invisible. A person who, as a child, felt flawed and worthless becomes a perfectionist. A person whose needs as a child were not met becomes defiant and demanding. A person whose childhood longing for bonding and connection was not met becomes fiercely independent and seems to need nobody. Overcompensation can thus be thought of as a *fight* response.

Overcompensations often work up to a point and allow individuals to function more effectively in the world than if they were surrendered to, or completely cut off from their maladaptive schemas. However, they have two drawbacks. First the underlying schemas remain intact. This means that when the compensation fails, the schemas can be triggered and the individual is overcome with intense feelings and is often confused about where the emotions comes from. For example, individuals who overcompensate for a defectiveness/shame schema by being perfectionistic may experience intense

shame in situations where their perfectionism fails to produce results that meet their standards. Second, the overcompensatory behaviour can reinforce the underlying schemas. Similarly, a person who is controlling and demanding is likely to irritate others and push them away. This creates further evidence for underlying schemas associated with beliefs that other people do not really care. Thus, overcompensations are also usually self-defeating in the end.

Schema modes

Another aspect of schema organization is that one or more schemas may function together to form a stable mode that functions like a kind of sub-personality. Individuals have several modes and may switch between them in ways that are confusing for other people (because it is as if the person has undergone a personality change) and may also be confusing for the individual (who will feel completely different, depending on which mode is active).

The main classes of modes are summarized below, and there is a longer list is in Appendix B. Note that your therapist will help you identify your own distinctive modes, some of which may not necessarily be the same as the examples given. You may be asked to complete the *Schema Mode Inventory* as a way of identifying your prominent modes.

1. Healthy modes

Healthy functioning calls for the capacity to obtain and integrate information, identify and solve problems, and make balanced evaluations and decisions in the various domains of life so that activities are pursued in a balanced way. This leads to a sense of meaning and fulfillment in work, in intimate and social relationships, as well as sporting, cultural, and service-related activities. This involves being aware of feelings and their meaning, taking responsibility for choices and actions, and making and keeping commitments. This is the *Healthy Adult* mode. A child whose needs are met feels safe and contented, has a sense of personal connection to others, experiences excitement and curiosity about life and the world, and has a spontaneous capacity for happiness and contentment. These are the characteristics of the *Happy or Contented Child* mode.

2. Damaged child modes

These modes carry the experience of the child whose needs were not met. When a person experiences these childhood schemas, we say that they are in *Vulnerable Child* mode. Often the vulnerable child has distinctive experiences that may be captured by referring to the *Abandoned Child* or the *Lonely Child* or the *Dependent Child* mode. In practice, we can personalize modes for each individual depending on the characteristic experience of the mode and the predominant schemas around which it is organized. Another set of child modes are responses developed in childhood due to neglect or abuse. These are the *Angry Child* mode and the *Enraged Child*. When these modes are activated, individuals become irrationally angry or even destructive. The *Impulsive Child* and *Undisciplined Child* modes may develop when parenting is too permissive and children are not treated with appropriate firmness, or when parents fail to provide the support towards building appropriate motivation in the child, or as a reaction to overly harsh discipline.

3. Coping modes

Coping modes develop as a way of coping with the emotional distress in the *Vulnerable Child* and can usually be classified under the three classes of coping discussed above under **Schema Processes**.

3.1 Surrender modes: At times, when vulnerable child modes are triggered, people act as if the beliefs associated with these modes are accurate and the associated feelings are, therefore, inevitable. In the *Compliant Surrenderer* mode they cope with this by pleasing, placating, and helping other people, while subordinating their own true feelings and needs. There is also a *Poor Me/Victim* mode in which people feel the distress of the child but disempower themselves by focusing on self-pity.

3.2 Protector/avoidance modes: In these modes we cut off from the emotional pain associated with our underlying EMSs. In *Avoidant Protector* Mode we simply avoid people, activities or places that might act as triggers. In *Detached Protector* Mode we cut off from our feelings and go about in an emotionally numb or robotic state. In *Angry Protector* mode we cover what we are really feeling with a stream of resentment and anger to shut others out from our vulnerability. In *Detached Self-Soother* mode we avoid what we are really feeling by resorting to activities like comfort eating, using alcohol and other drugs, or compulsive use of pornography or the internet. All these modes perpetuate the EMSs and prevent resolution and healing. They usually also add to our problems in significant ways.

3.3 Overcompensator modes: In these modes we act in a way that is the opposite of how we are when an EMS is triggered. A person who feels in need of others and dependent on them may act in a strong and independent manner. In *Self-Aggrandiser* mode, people who feels worthless or unlovable at the child level may act as if they are great, and resort to seeking admiration and placing themselves in a one-up position above others. In *Perfectionistic Overcontroller* mode people may give the impression of doing things very well and being in control, but at the child level they feel confused and out of control. As already mentioned, these strategies may work to some extent by helping us cope with life and get on in the world. However, they leave the vulnerable child untouched, and can lead to chronic alienation from spontaneity and authenticity.

4. Dysfunctional parent modes

Individuals behave towards themselves like dysfunctional parents, for example, by placing upon themselves unrealistic demands for achievement or self-control (*Demanding Parent),* or by scolding, criticizing and belittling themselves (*Punitive Parent*). These modes are internalized ("introjected") from experiences with parents or teachers.

Using an understanding of schemas and modes to develop a treatment plan

We can develop a schema-focused understanding of your problems by reviewing your characteristic behaviours in everyday situations, reviewing the areas in which you experience significant problems, and examining your life history. In addition, you may be asked to complete one or more self-report scales such as the *Young Schema Questionnaire*, the *Young Parenting Inventory* and the *Schema Mode Inventory*. On this basis we can identify your most significant EMSs and the associated core beliefs and emotional states, and how you cope with them through various forms of surrender, avoidance or

overcompensations. This can provide an understanding of how many of your problems may be caused by dysfunctional parent modes and coping modes.

This provides the basis for a comprehensive long term plan of action for changing the EMSs, building new more adaptive and self-enhancing behaviours, and findings ways to get your needs met on an ongoing basis in the contexts of your current life. This plan is likely to involve a wide range of activities, many of which can be understood as falling under the following three headings:

Healing the Vulnerable Child

Most EMSs are embedded in childhood experiences which were emotionally painful. These patterns continue into the future, driven by memories of critical experiences from long ago. As EMSs are activated, they allow us to get in touch with the memories from the past events that hurt us, and seemed to be impossible to resolve. It can be helpful to see how present-day feelings are actually memories of what happened in the past. In addition, the painful memories can, themselves, be addressed by way of rescripting them. This involves working with the *Vulnerable Child*, empathizing with him/her, and symbolically providing ways in which he/she can have these needs met that were not met at in the past.

Reducing the power of dysfunctional coping and parent modes

Coping modes prevent access to the child modes which are the source of spontaneity, authenticity and the capacity for meaningful interpersonal contact. They also create additional problems by giving rise to self-limiting, self-defeating, and self-destructive behaviours. These modes need to be identified and replaced with more effective and non-harmful ways of coping. Schema therapists help their clients to challenge avoidances. This will involve exposing yourself to situations, thoughts and feelings that you normally and automatically avoid. Your therapist will help you to plan this in a graded manner so that you can learn to tolerate uncomfortable feelings that might be evoked. Often these are feelings from childhood that can be worked with in therapy. They also help clients to relinquish overcompensatory behaviours because, although these may be adaptive to some extent, they also have the negative effect of distancing us from our genuine experience, and this can have a negative impact on interpersonal relationships. By giving up compensations, we will expose ourselves to EMSs which we have not wanted to experience. As these EMSs come into focus, they can be worked on and resolved in therapy (see **Healing the Vulnerable Child** above). This can lead to learning to interact in a more authentic and satisfying way.

Dysfunctional parent modes are also problematic. At the outset, they might appear to help to motivate you to get things done. But, on closer inspection, they have the opposite effect. A critical voice that constantly repeats demeaning messages and undermines your self-esteem makes it difficult to enjoy everyday activities and relationships. A demanding voice that keeps imposing rigid standards in the form of rules and “shoulds” creates chronic tension and dissatisfaction. Both these voices can activate an angry or rebellious child mode that refuses to be pushed around, resulting in procrastination or a lack of motivation. To identify these parent modes, the messages they give need to be closely scrutinized, and where deemed unhelpful, need to be stopped and banished.

Building the Healthy Adult

Often the effect of vulnerable child states, and the avoidances and compensations that are adopted to hide them, is that individuals find it difficult to remain in a balanced state from which they can exercise good judgment and have an accurate perception of their own and others' behaviour. Building this balanced *Healthy Adult* state is often an important focus of therapy. This increased the capacity to engage in relationships that are mutually respectful and effectively solve everyday problems . This might involve:

- *Building self-awareness and cultivating mindfulness:* to stay balanced we need to have an ongoing awareness of our emotional states and how they are activated in different situations. At the same time we need to be able to distance from these states like an observer who can see and not what they are without getting caught up in them and carried away.
- *Building an understanding of how EMSs and schema modes work:* This will help you step back and see clearly what you need to do to break out of the patterns, and how the various aspects of schema therapy can contribute to empowering you to do this.
- *Addressing cognitive distortions*: involves identifying beliefs, assumptions, and everyday thoughts that are inaccurate and serve to maintain the schema. You can actively challenging the distortions on the basis of reason and examination of evidence in real-life situations.
- *Behavioural experiments/behavioural pattern-breaking:* involves experimenting with new ways of behaving to replace your current self-defeating behaviours. In behavioural experiments, you will learn what works for you by trying out new behaviours which are likely to be more effective, and by examining the effects of these new behaviours. Through pattern-breaking, we work to break the power of self-defeating patterns, and replace them with new ones that will help you to lead a more satisfying life.
- *Cultivating self-enhancing activities and behaviours:* This means identifying what you want out of life and looking at ways of engaging in activities and relationships that are likely to be meaningful and satisfying for you. This involves evaluating your current goals and setting new ones. It is particularly important to reevaluate goals driven by schema overcompensation, because when such goals are achieved, the satisfaction is usually short-lived. These need to be continually worked with in order to weave them into the fabric of your everyday life.
- *Learning to use feelings as a guide to behaviour:* As the healing process takes place in the *Vulnerable Child*, you will have more and more access to what you really feel about everyday situations and relationships, and the decisions you will need to make. You will be able to integrate these feelings into problem-solving processes, and increasingly decision-making that results in your getting your needs met and enjoying a greater sense of satisfaction out of life.

Working with relationships

In human relationships, individuals often relate to each other through their coping modes. When this happens the relationship is problematic because neither party is in a balanced *Healthy Adult* state. Sometimes one party may flip into a Child mode such as *Angry Child* or *Abandoned Child*. If the other party continues to respond from a coping mode then the person in the Child mode will have a further

experience of their needs not being met and this will add to the store of painful memories associated with early maladaptive schemas. When this happens the two individuals get caught in a mode cycle, a sequence of coping and child modes in which both increasingly feel their needs are not being met, and which is bound to have an unsatisfactory outcome.

In individual therapy, a person can learn to understand how mode cycles work in important relationships and experiment with ways to break the cycle. Sometimes, however, it can be better for both (or all) parties to work with the therapist together. For spouses or romantic partners, this would mean, having sessions as a couple. For other family relationships, parent-child or whole family sessions can help to achieve this. The focus of the therapy would then be on identifying self-defeating mode cycles and finding ways to interrupt them and replace them with mature and authentic ways of relating that will be more supportive and satisfying.

For further reading and information

For more resources visit http://www.schematherapysouthafrica.co.za/ and the dedicated page on schema therapy: http://www.schematherapysouthafrica.co.za/schema-therapy/ or read one of the books below:

Arntz, A. & Jacob, G. (2012). ***Schema Therapy in practice*.** Oxford: Wiley/Blackwell. *An introduction for non–specialist practitioners by two pioneers of the schema mode approach.*

Farrell, J.M., Reis, N., & Shaw, J. (2014). **The schema therapy clinician's guide: A complete resource for building and delivering individual, group and integrated schema mode treatment programs**. Chichester: Wiley-Blackwell.

Farrell, J. M. & Shaw, I. A. (2018). **Experiencing schema therapy from the inside out: A self-practice/self-reflection workbook for therapists**. New York: Guilford. *But not only for therapists!*

Jacob,G., van Genderen, H., & Seebauer, L. (2015). ***Breaking negative thinking patterns.*** Chichester: Wiley-Blackwell. *A self-book with a focus on schema modes.*

Rafaeli, E., Bernstein, D. P. & Young, J. (2011). ***Schema Therapy*** (The CBT Distinctive features series). London: Routledge. *A clear summary for clients and therapists. The focus is on the distinctive features of schema therapy in relation to other contemporary integrative therapies.*

Roediger, E., Stevens, B. A., & Brockman, R. (2018). **Contextual schema therapy: An integrative approach to personality disorders, emotional dysregulation, and interpersonal functioning**. Oakland, CA: New Harbinger.Young, J. E. & Klosko, J. (1994). ***Reinventing your life***. New York: Plume. *A great book for clients in schema therapy, but it's a good read for therapists too.*

Simpson, S. & Smith, E. (Eds) (2019). **Schema therapy for eating disorders: Theory, practice and group-treatment manual**. London: Routledge.

Young, J. E., Klosko, J., & Weishaar, M. E. (2003). ***Schema therapy: A practitioner's guide***. New York: Guilford. *A comprehensive guide resource with all the theory and many clinical examples. This is a must for therapists, but some clients might also enjoy reading it*.

Appendix A

Early Maladaptive Schemas as defined by Jeffrey Young

(in the order they appear in the YSQ-3)

1 **EMOTIONAL DEPRIVATION:** The expectation that one's desire for a normal degree of emotional support will not be adequately met by others. The three major forms of deprivation are:

Deprivation of Nurturance: Absence of attention, affection, warmth, or companionship.

Deprivation of Empathy: Absence of understanding, listening, self-disclosure, or mutual sharing of feelings from others.

Deprivation of Protection: Absence of strength, direction, or guidance from others.

2 **ABANDONMENT:** The perceived *instability* or *unreliability* of those available for support and connection. Involves the sense that significant others will not be able to continue providing emotional support, connection, strength, or practical protection, because they are emotionally unstable and unpredictable (e.g., angry outbursts), unreliable, erratically present, or because they will die imminently or abandon the patient in favor of someone better.

3 **MISTRUST:** The expectation that others will hurt, abuse, humiliate, cheat, lie, manipulate, or take advantage. Usually involves the perception that the harm is intentional, or the result of unjustified and extreme negligence. May include the sense that one always ends up being cheated relative to others, or "getting the short end of the stick."

4 **SOCIAL ISOLATION / ALIENATION:** The feeling that one is isolated from the rest of the world, different from other people, and/or not part of any group or community.

5 **DEFECTIVENESS / SHAME** : The feeling that one is defective, bad, unwanted, inferior, or invalid in important respects; or that one would be unlovable to significant others if exposed. May involve hypersensitivity to criticism, rejection, and blame; self-consciousness, comparisons, and insecurity around others; or a sense of shame regarding one's perceived flaws. These flaws may be **private** (e.g., selfishness, angry impulses, unacceptable sexual desires) or **public** (e.g., undesirable physical appearance, social awkwardness).

6 **FAILURE**: The belief that one has failed, will inevitably fail, or is fundamentally inadequate relative to one's peers in areas of *achievement* (school, career, sports, etc.). Often involves beliefs that one is stupid, inept, untalented, ignorant, lower in status, and less successful than others, etc.

7 **INCOMPETENCE / DEPENDENCE** : The belief that one is unable to handle one's *everyday responsibilities* in a competent manner without considerable help from others (e.g., take care of oneself, solve daily problems, exercise good judgment, tackle new tasks, or make good decisions). Often presents as helplessness.

8 **VULNERABILITY TO HARM OR ILLNESS:** Exaggerated fear that *imminent* catastrophe will strike at any time and that one will be unable to prevent it. Fears focus on one or more of the following: *Medical Catastrophes*: e.g., heart attacks, AIDS; *Emotional Catastrophes*: e.g., going crazy; and *External Catastrophes*: e.g., elevators collapsing, victimized by criminals, airplane crashes, earthquakes.

9. **ENMESHMENT**: Excessive emotional involvement and closeness with one or more significant others (often parents) at the expense of full individuation or normal social development. Often involves the belief that at least one of the enmeshed individuals cannot survive or be happy without the constant support of the other. May also include feelings of being smothered by, or fused with,

others, or insufficient individual identity. Often experienced as a feeling of emptiness and floundering, having no direction, or in extreme cases, questioning one's existence.

10. **SUBJUGATION:** Excessive surrendering of control to others because one feels *coerced* — usually to avoid anger, retaliation, or abandonment. The two major forms of subjugation are:

    a. **Subjugation of Needs:** Suppression of one's preferences, decisions, and desires.

    b. ***Subjugation of Emotions:*** Suppression of emotional expression, especially anger.

    Usually involves the perception that one's own desires, opinions, and feelings are not valid or important to others. Frequently presents as excessive compliance, combined with hypersensitivity to feeling trapped. Generally leads to a build up of anger, manifested in maladaptive symptoms (e.g., passive-aggressive behavior, uncontrolled outbursts of temper, psychosomatic symptoms, withdrawal of affection, "acting out", and substance abuse).

11. **SELF-SACRIFICE:** Excessive focus on *voluntarily* meeting the needs of others in daily situations, at the expense of one's own gratification. The most common reasons are: to prevent causing pain to others; to avoid guilt from feeling selfish; or to maintain the connection with others perceived as needy . Often results from an acute sensitivity to the pain of others. Sometimes leads to a sense that one's own needs are not being adequately met and to resentment of those who are taken care of. (Overlaps with concept of co-dependency.)

12. **EMOTIONAL INHIBITION:** The excessive inhibition of spontaneous action, feeling, or communication - usually to avoid disapproval from others, feelings of shame, or losing control of one's impulses. The most common areas of inhibition involve:

    a. inhibition of *anger & aggression*;

    b. inhibition of *positive impulses* (e.g., joy, affection, sexual excitement, play);

    c. difficulty expressing *vulnerability* or *communicating* freely about one's feelings, needs, etc., or

    d. excessive emphasis on *rationality* while disregarding emotions.

13. **UNRELENTING STANDARDS:** The underlying belief that one must strive to meet very high *internalized standards* of behavior and performance, usually to avoid criticism. Typically results in feelings of pressure or difficulty slowing down; and a hypercritical nature toward oneself and others. Must involve significant impairment in: pleasure, relaxation, health, self-esteem, sense of accomplishment, or satisfying relationships. Unrelenting standards typically present as:

    a. ***perfectionism*****:** inordinate attention to detail, or an underestimate of how good one's own performance is relative to the norm;

    b. ***rigid rules*** and "shoulds" in many areas of life, including unrealistically high moral, ethical, cultural, or religious precepts; or

    c. ***preoccupation with time and efficiency,*** so that more can be accomplished.

14. **ENTITLEMENT/SUPERIORITY:** The belief that one is superior to other people; entitled to special rights and privileges; or not bound by the rules of reciprocity that guide normal social interaction. Often involves insistence that one should be able to do or have whatever one wants, regardless of what is realistic, what others consider reasonable, or the cost to others; OR an exaggerated focus on superiority (e.g., being among the most successful, famous, wealthy) in order to achieve *power* or *control* (not primarily for attention or approval). Sometimes includes excessive competitiveness toward, or domination of others, asserting one's power, forcing one's point of view, or controlling the behavior of others in line with one's own desires without empathy or

concern for others' needs or feelings.

15. **INSUFFICIENT SELF-CONTROL / SELF-DISCIPLINE:** Pervasive difficulty or refusal to exercise sufficient self-control and frustration tolerance to achieve one's personal goals, or to restrain the excessive expression of one's emotions and impulses. In its milder form a patient presents with an exaggerated emphasis on ***discomfort-avoidance***: avoiding pain, conflict, confrontation, responsibility, or overexertion at the expense of personal fulfillment, commitment, or integrity.

16. **ADMIRATION/RECOGNITION-SEEKING:** Excessive emphasis on gaining approval, recognition, or attention from other people, or fitting in at the expense of developing a secure and true sense of self. One's sense of esteem is dependent primarily on the reactions of others, rather than on one's own natural inclinations. Sometimes includes an overemphasis on status, appearance, social acceptance, money, or achievement as means of gaining *approval, admiration,* or *attention* (not primarily for power or control). Frequently results in major life decisions that are inauthentic or unsatisfying, or in hypersensitivity to rejection.

17. **PESSIMISM/WORRY:** A pervasive, life-long focus on the negative aspects of life (pain, death, loss, disappointment, conflict, guilt, resentment, unsolved problems, potential mistakes, betrayal, things that could go wrong, etc., while minimizing or neglecting the positive or optimistic aspects. Usually includes an exaggerated expectation in a wide range of work, financial, or interpersonal situations; that things will eventually go seriously wrong; or that aspects of one's life that seem to be going well will ultimately fall apart. Usually involves an inordinate fear of making mistakes that might lead to financial collapse, loss, humiliation, or being trapped in a bad situation. Because potential negative outcomes are exaggerated, these patients are frequently characterized by chronic worry, vigilance, complaining, or indecision.

18. **SELF-PUNITIVENESS:** The belief that people should be harshly punished for making mistakes. Involves the tendency to be angry, intolerant, punitive, and impatient with those people (including oneself) who do not meet one's expectations or standards. Usually includes a difficulty forgiving mistakes in oneself or others due to a reluctance to consider extenuating circumstances, or a difficulty allowing for human imperfection, or empathizing with feelings.

Source: www.schematherapy.com

Appendix B: Definitions of schema modes

Modified and expanded from 22 modes identified by Lobbestael, van Vreeswijk, and Arntz (2007).

Healthy adult

This mode performs appropriate adult functions such as obtaining information, evaluating, problem-solving, working, and parenting. Does these things in a balanced and rational way, showing respect for own needs as well as respects for needs of others. Takes responsibility for choices and actions, and also makes and keeps commitments. Is humanly (emotionally) present and shows emotional intelligence, balancing appreciation of realistic concerns and emotional aspects (wise mind).

Child modes

1. Vulnerable Child modes

Lonely Child: feels alone with no one to turn to when faced with confusing or distressing experiences or situations. Because parents have not been available physically or emotionally to help the child with difficult emotions, the person feels empty, alone, socially unacceptable, undeserving of love, unloved and unlovable.

Abandoned Child: An intense and engulfing experience of being all alone in an endless dark place. Often the result of very early experiences of separation from the mother or other primary caretaker.

Abused Child: feels helpless, hopeless, frightened, defenceless, and lost. Anticipates neglect and abuse and there is usually a strong *Punitive Parent* voice.

Humiliated / Shamed Child: feels worthless and incapacitated by shame, anticipates further humiliation.

Dependent Child: feels incapable making own decisions and overwhelmed by adult responsibilities. Believes that s/he needs a strong person at his/her side to guide hium/her and make the right decisions. Usually the result of overprotective parents who failed to encourage development of autonomy and self-reliance.

2. Angry/Unsocialized Child modes

Angry child: feels intensely angry, enraged, infuriated, frustrated, or inpatient because the core emotional (or physical) needs of the vulnerable child are not being met. Vents 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 results in hurting or damaging people or objects. The displayed anger is out of control and has the goal of destroying the aggressor, sometimes literally. It has the affect of an enraged or uncontrollable child, screaming or acting out impulsively to an (alleged) perpetrator.

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 self or others. He/she 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 gives up soon.

3. Healthy child modes

Happy/Contented Child: Feels at peace because core emotional needs are currently met. S/he 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.

Creative/authentic child: The source of creativity, curiosity, playfulness and a sense of authentic engagement with life.

Maladaptive coping modes

1. Surrender modes

Compliant Surrenderer: 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.

Self-pity victim: self-pitying, "Poor me," expects to be given special treatment because one is a victim and wants people to see it. Often accompanied by complaining.

Surrender to Damaged Child modes: In these modes individuals behave as if they are like the child, with the same beliefs, emotions and behaviours as when the childhood pattern was set up.

2. Detched / Avoidant modes

Detached protector: withdraws psychologically from the pain of the EMSs by emotionally detaching. Shuts off all emotions, disconnects from others, rejects help, and functions in an almost robotic manner. May remain quite functional.

Spaced out Protector: shuts off emotions by spacing out or feeling sleepy. Can give rise to an experience of being foggy or even unreal, and gives rise to dysfunctional states of cognitive slowing and depersonalization.

Avoidant Protector: avoids triggering by behavioural avoidance and keeps away from situations or cues that my trigger distress.

Detached Self-Soother: shuts off emotions by engaging in activities that soothe, stimulate or distract. These behaviours are often addictive or compulsive and can include overeating, workaholism, gambling, dangerous sports, promiscuous sex, drug abuse. Includes solitary compulsive behaviours such as playing computer games, watching television, or fantasizing.

Angry Protector: uses a 'wall of anger' to protect him/herself from others who are perceived as threatening. Displays of anger serve to keep others at a safe distance to protect against being hurt.

3. Overcompensation modes

Attention and Approval Seeker tries to get others' attention and approval by extravagant, inappropriate and exaggerated behaviour. Usually compensates for underlying loneliness.

Self-Aggrandiser: behaves in an entitled, competitive, grandiose, abusive, or status-seeking way. Is almost completely self-absorbed, and show little empathy for the needs or feelings of others. Expects to be treated as special, and does not believe s/he should have to follow the rules that apply to everyone else. Brags or behaves in a self-aggrandizing manner to inflate sense of self.

Overcontrollers: These protect from perceived or real threat by focusing attention on details, ruminating, and exercising extreme control. A *Perfectionistic Overcontroller* focuses on getting things perfect to attain a sense of control and safety and ward off misfortune and criticism. An *Eating Disordered Overcontroller* relentlessly applies perfectionist rules to body mass and diet. A *Suspicious Overcontroller* vigilantly scans other people for signs of malevolence, and attempts to controls others'

behaviour to prevent mistreatment or betrayal. A *Scolding Overcontroller* issues orders to others and makes belittling remarks as a way of controlling their behaviour. A *Worrying Overcontroller* ruminates excessively on things that can go wrong and how to fix them. This is usually a way of trying to compensates for inability to tolerate uncertainty. Some people with this mode believe that worrying helps them cope better. A *Compulsive Overcontroller* suppresses uncomfortable feelings by neutralizing them with repetitive ritualistic behaviours which may be overt (repetitive washing or checking or tidying and cleaning the house), or covert (such as repeating words or phrases intended to neutralize whatever uncomfortable emotion has been triggered).

Pollyanna Overcompensator: First identified in people with eating disorders, but by no means confided to them, this mode "maintains persistently positive attitude, even in the face of difficult events and interpersonal tensions. Avoids genuine assertiveness and minimizes feelings that might lead to criticism or rejection (e.g. authentic anger, sadness, shame). Excessive 'positive thinking', finds a 'silver lining' even in the most difficult situations or circumstances, whilst unwittingly invalidating one's own or others' struggles and difficulties. May use platitudes such as 'Everything happens for a reason', 'It was meant to be', as a means of attempting to reduce others' feelings of vulnerability in times of adversity" (Simpson, 2019).

4. Antisocial modes

Several extreme forms of compensation that result in abusive and even criminal behaviour:

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

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

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

Maladaptive Parent Modes

Punitive Parent: Internalized voice of parent (or other caretaker/teacher), criticizing, punishing and shaming in a harsh, critical, and unforgiving way with the result that you believe you are worthless and deserve punishment..

Demanding Parent: Internalized voice of parent that continually pushes and pressures you to meet excessively high standards. Speaks with "shoulds" and sets rigid rules and standards.

Guilt-inducing Parent: Internalized voice of parent that combines punitive and demanding aspects and induces guilt by inculcating the belief that you "should" have acted in a certain way, and are "bad" for not having done so.

Overprotective Parent: Internalized voice of parent that tells you that you can't cope on your own, can't make your own decisions, don't know what you feel, and must listen to this voice in order to find out.

References

Lobbestael, J., van Vreeswijk, M., & Arntz, A. (2007). Shedding light on schema modes: a clarification of the mode concept and its current research status. *Netherlands Journal of Psychology, 63,* 76-85.

Simpson, S. (2019). Assessment and Schema Mode Conceptualisation in Eating Disorders. In S. Simpson & E. Smith (Eds), *Schema therapy for eating disorders: Theory, practice and group-treatment manual*. London: Routledge.