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Maria Finogenow

# SCHEMA MODES AND MODE MODELS FOR CLUSTER B AND C PERSONALITY DISORDERS

University of Lodz, Institute of Psychology

**schema therapy**
**schema modes**
**personality disorders**

**Summary**

Schema therapy, created by Jeffrey Young and co-workers, is a relatively new integrative approach in psychotherapy. Although it is derived directly from cognitive theory, it also contains some elements of the attachment theory by Bowlby, transactional analysis by Berne, object-relations theory, Gestalt, and person-centred concepts.

The key notion in the model by Young and co-workers relates to Early Maladaptive Schemas, which are referred to as general overwhelming motives or patterns that comprise recollections, emotions, beliefs, and physical experiences. The first description of the schema model turned out to have some limitations in the clinical treatment of patients with serious personality disorders. Young proposed Schema Modes Model as a more effective alternative to be used in the treatment of the disorders. After the development of the mode model for borderline and narcissistic personality disorder, also models for other personality disorders were elaborated.

The article is aimed at presenting the schema modes and the mode models for persons with personality disorders. There are presented mode models for cluster B personality disorders (borderline, narcissistic, histrionic, antisocial) and for cluster C personality disorders (avoidant, dependent, obsessive-compulsive).

## Introduction

Schema therapy, created by Jeffrey Young and co-workers [1–3], is a relatively new integrative approach in psychotherapy. It is derived from cognitive-behavioural therapy, yet it combines also some elements of other concepts, including mainly the attachment theory by Bowlby, transactional analysis by Berne, object-relations theory, *Gestalt*, and person-centred concepts. As opposed to classical cognitive-behavioural therapy, the schema therapy underlines the role of the therapeutic relationship and emotion-centred techniques [3, 4]. In schema therapy, more attention is focused upon working with problematic emotions, which is based on the assumption that a change in cognitive functioning does not necessarily mean an improvement in emotional regulation [5].

The key notion in the schema therapy relates to early maladaptive schemas, which are formed in childhood as a result of interactions among varied factors: a child's temperament,

parental styles, and some significant, sometimes traumatic, experiences. The schemas contain sensations, experienced emotions and activities, and also significance that has been attributed to them. They function as filters which are used to organise, interpret, and predict the world [2–4, 6].

An important role in the development of maladaptive schemas is played by lack of fulfilment of the basic childhood needs, which – according to Young – comprise as follows: the need of secure attachment, autonomy, acknowledgement, realistic borders, and spontaneity and joy. The model by Young and co-workers [3, 6] contains descriptions of 18 maladaptive schemas, which have been classified to five major areas related to basic needs, *e.g.* the schema of Emotional Deprivation, Defectiveness, Dependence/Incompetence. According to Young, people cope with these emotions using three main styles of coping: overcompensation, surrendering to a schema, or avoiding a schema. Coping strategies that are related to the three styles are perceived by Young as crucial in maintaining the schemas [3, 7].

## Schema Modes

The first description of the schema model turned out to have some limitations in the clinical treatment of patients with serious personality disorders [3, 4]. The difficulties resulted from both numerous schemas present in those patients and also some rapid changes in the ways of their thinking, feeling, and behaving. To explain the changes better, Young and co-workers proposed the Schema Modes Model as a more effective alternative to be used in the treatment of the disorders [3, 4, 6]. Schema Modes, called modes, in short, are patterns of thinking, feeling, and behaving that are relatively independent of one another and that present the basis for varied states of consciousness. They may be observed and measured as they represent momentary emotional and cognitive states and ways of coping that are active in a particular moment. The modes become activated by emotional events and a person may switch from one mode to another one very quickly.

At first, Young and co-workers [3, 6] distinguished 10 basic modes, which were classified to four categories: child modes (Vulnerable Child[1], Angry Child, Impulsive and Undisciplined Child, Happy Child), maladaptive coping modes (Compliant Surrender, Detached Protector, Over-Compensator), maladaptive parental modes (Punitive Parent and Demanding Parent), and the Healthy Adult mode. Only two modes from among the enumerated ones are referred to as adaptive: the Happy Child mode and the Healthy Adult mode.

[1] In the Polish literature, there is a variety of naming of some modes. Translation proposals given by the authors, together with the original names, are included in Table 1 of the Polish full text.

The Vulnerable Child mode may take on varied subtypes depending on the wounds inflicted on a child, *e.g.* the Lonely Child, Abused Child, Deprived Child, or Defective Child [3]. In this mode, a patient suffers from numerous painful emotions and is very sensitive to hurt. Most of the schemas belong to this mode and that is why it is central in working with schemas. Curing this mode is the most significant goal in therapy. Moreover, the child modes may be related to experiencing intense anger and difficulties with self-discipline.

Maladaptive coping modes correspond to the three basic styles of coping suggested by Young (surrendering to a schema, avoiding a schema, and overcompensation, *i.e.* fighting a schema). These modes reflect attempts that a patient was making as a child to cope with unfulfilled needs. It may be often observed that the modes played an adaptive role in a patient's childhood, yet in adulthood, they have become a source of suffering and numerous problems for the patient. The role of the Compliant Surrender often consists in avoiding some further harm by means of surrendering to a schema, the role of the Detached Protector is to escape from difficult emotions by means of withdrawal and emotional cutting-off, whereas the role of the Over-Compensator is also to escape from difficult emotions but this time by means of behaviours which are aimed at denying schema contents. Besides the ten major modes, Young and co-workers [3, 4] indicated also the Self-Aggrandiser mode and the Bully and Attack mode as subtypes of overcompensation, and the Detached Self-Soother mode as a subtype of the avoiding mode.

Maladaptive parental modes reflect internalised figures of a parent or significant others from the period of childhood. When patients function within these modes, they treat themselves the same way they were treated by their parents. Depending on their childhood experiences, they most often punish themselves for expressing needs or making mistakes (Punitive Parent) or exert pressure to fulfil unrealistic, high demands (Demanding Parent).

In the course of developing and broadening the approach by research groups of Arnoud Arntz and David P. Bernstein, subsequent modes were introduced and described. For instance, Bernstein and co-workers [8, 9] suggested to enrich the ten-mode model by Young with four new modes that could help elaborate mode models for persons with psychopathic personality traits: Angry Protector, Predator, Conning and Manipulative, and Over-Controller. According to Bamelis and co-workers [10], the latter mode may take the form of Perfectionist or Paranoid Over-Controller, whilst in Edwards' analysis of functioning within the 'dramatic triangle' also Scolding Over-Controller and the Victim mode are described [11].

At the moment, there are over 20 modes described in the literature (Table 1). Some of them have been distinguished as specific subtypes of former modes, some others have been elaborated on the basis of working with patients with varied personality disorders. As the mode-based approach was developing, Mode Models for different disorders were formed. They describe modes that are

most frequent among patients with a given disorder, and they present the basis for models of working with a patient presenting a particular disorder.

Table 1. **Mode characteristics**

| **MALADAPTIVE CHILD MODES** |
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| **Vulnerable Child*** |
| **Lonely Child** The patient feels like a child who is alone. As in childhood the patient's needs were not fulfilled, he/she often has the sense of emotional emptiness. The patient feels lonely, unaccepted, unloved, and unworthy of love. |
| **Abandoned and Abused Child** The patient feels great pain and fear because of having been left and/or abused. He/she feels like a lost, helpless child who has been abandoned. The patient is terrified, sad, desperate, feels unworthy, confused, and needy. In this mode, the patient is insistent in the quest for a figure of a parent, who could provide him/her with care. |
| **Humiliated and Inferior Child** This mode is referred to as a subcategory of the Abandoned and Abused Child mode. The sense of being lonely is weaker in this mode. Dominating is the sense of being humiliated and inferior from others. The patient feels ashamed and excluded. |
| **Dependent Child** The patient feels incapable and overwhelmed by adults' duties. He/she is insistent in the quest for a person who can give care and emotional support, show a way, and take his/her responsibility. |
| **Angry Child*** |
| **Angry Child** The patient feels intense anger, rage, and impatience because his/her basic needs are not being fulfilled. He/she may also feel abandoned, humiliated, or betrayed. The patient manifests his/her anger intensively both in verbal and nonverbal ways, as it is done by a small child who displays outbursts of anger. The patient rebels against injustice he/she experiences, yet does not attack others. |
| **Stubborn Child** This is a subtype of the Angry Child. The patient feels anger but does not express it openly. Instead of that, he/she insists on his/her position or expectations that are perceived by others as unreasonable. |
| **Enraged Child** The patient feels anger and rage because of the same reason as observed for the Angry Child, but he/she loses control. This is displayed in insulting, attacking, and harming/destructive behaviours towards other people and things. The patient behaves like an enraged child who destroys his/her toys. |
| **Impulsive and Undisciplined Child*** |
| **Impulsive Child** In this mode, the patient relieves all his/her blocked emotions in an impulsive and sudden way so as to fulfil his/her needs immediately. However, it is often the case that the patient's behaviours are aimed at meeting not basic needs but momentary whims. The patient is not able to postpone gratification nor to foresee negative consequences of his/her impulsive activities. |
| **Undisciplined Child** The patient has no tolerance for frustration and cannot force himself/herself to complete some routine or boring tasks. He/she is not able to stand lack of satisfaction or discomfort and behaves like a spoilt child. The patient gives up easily. |
| **MALADAPTIVE COPING MODES** |
| **Surrendering to a schema** |
| **Compliant Surrender*** The patient sacrifices himself/herself and complies with needs and expectations of others so as to avoid negative consequences, *e.g.* a conflict or rejection. He/she suppresses his/her needs and emotions in hopes of gaining acceptance for being obedient. The patient tolerates being abused by others. He/she becomes engaged in such activities and relations that are consistent with the contents of his/her schemas. |
| **Self-pity Victim** The patient feels great suffering but does not undertake any activities that could help him/her fulfil his/her needs. Instead of that, the patient behaves like a victim, complains and feels sorry for himself/herself. |
| **Avoiding a schema** |
| **Detached Protector*** The patient cuts off from strong feelings and emotions because he/she believes that the feelings are dangerous and they may get out of control. The patient withdraws from social contacts and tries to cut off from emotions (which sometimes leads to the state of dissociation). The patient feels empty, bored, and impersonal. He/she may take a cynical or pessimistic approach to keep others at a distance. |

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| **Detached Self-Soother/Self-Stimulator** The patient looks for distractors to avoid negative emotions. He/she achieves this aim by means of relaxing activities (*e.g.* sleep, psychoactive substances) or self-stimulating activities (*e.g.* intense and excessive involvement in work, Internet, sport, sex). |
| **Angry Protector** The patient hides his/her real feelings, expresses anger and irritation instead of them. In fear of being hurt he/she seeks protection behind the wall of anger. Demonstrating anger is to keep others at a safe distance. As opposed to the Angry Child or the Enraged Child mode, the patient controls anger better. |
| **Avoidant Protector** The patient avoids situations or other stimuli that could harm him/her and evoke unpleasant emotions. Avoiding may apply both to interpersonal relations and to tasks which are difficult. |
| **Over-Compensator*** |
| **Self-Aggrandiser** The patient believes he/she is better than others and deserves some special rights. The patient insists on doing or having what he/she wants regardless of what others think or feel. The patient shows off, extols, and exposes his/her resources, *e.g.* appearance, position, and downgrades others to heighten his/her self-esteem. The patient often feels angry when someone tries to degrade his/her image. |
| **Bully and Attack** The patient wants to protect himself/herself from control or harm from others and that is why he/she tries to control others. The patient uses threats, terror, aggression, and strength. He/she always wants to dominate and derives sadistic pleasure from harming others. Aggressive behaviours are 'hot', spontaneous, they result from strong emotions that are being experienced at a given moment. |
| **Perfectionist/Obsessive Over-Controller** This mode is a subtype of the Over-Controller mode. The patient tries to protect himself/herself from a real or imagined threat by means of keeping everything under excessive control. In order to achieve this, he/she repeats activities, uses rituals, performs tasks in a perfectionist way. This mode is a frequent answer to high demands from a parent who was making his/her child feel incompetent or not good enough. |
| **Paranoid Over-Controller** This is the second subtype of the Over-Controller mode. The patient tries to protect himself/herself from a threat by means of increased vigilance. He/she is suspicious and focuses on controlling and supervising others. The patient is sure others have malicious intentions and tries to reveal them. |
| **Scolding Over-Controller** In the third subtype of the Over-Controller mode, the patient tries to control behaviours of others by criticising them, scolding, and a directive way of telling them what and how they should do. |
| **Conning and Manipulative** The patient manipulates, lies, and behaves in a dishonest way so as to destroy others or to avoid punishment. This mode is common among criminals, but also in narcissistic persons, who try this way to gain what they want. |
| **Predator** In this mode, the patient focuses on eliminating a threat, a rival, or an obstacle in an unscrupulous way. His/her aggression is cold, calculated, merciless, and ruthless. This mode is present mainly in persons with psychopathy. |
| **Attention Seeker** The patient tries to gain attention and acknowledgement from others by means of extravagant, inadequate, and exaggerated behaviours. He/she usually tries to compensate feelings of sadness and loneliness in this way. |
| **MALADAPTIVE PARENTAL MODES** |
| **Punitive (Critical) Parent*** The patient is aggressive, intolerant, impatient, and finds no excuses for himself/herself. He/she is always self-critical and feels guilty. The patient is ashamed of his/her mistakes and believes he/she must be punished for them severely. This mode is a reflection of the way parents (or one parent) or other significant persons used to talk to the patient in order to depreciate, ignore, or punish him/her. |
| **Demanding Parent*** The patient feels obliged to submit to severe, rigorous norms, rules, and values. He/she must be extremely effective in realizing them. The patient believes that whatever he/she does it is not good enough and he/she should try harder. That is why the patient strives after the highest standards, until the effect is perfect, and at the expense of rest and pleasure. He/she is hardly ever satisfied with the obtained results. |
| **HEALTHY MODES** |
| **Healthy Adult*** The patient has positive and neutral thoughts and feelings about himself/herself. He/she does what is good for himself/herself and this leads him/her to healthy relations with others and healthy activities. The patient cares about the needs of the Vulnerable Child, protects and values the child. He/she sets healthy boundaries to the Impulsive and Angry Child, limits and stops maladaptive coping styles and dysfunctional parental modes. |
| **Happy (Contented) Child*** The patient feels loved, understood, important, satisfied, and |

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| protected. He/she feels that relationships can be safe and supportive. He/she is self-confident and feels competent, properly autonomous, optimistic. The patient is playful and joyful like a happy child. |

* basic modes distinguished by Young and co-workers (2013)

Source: the author's elaboration based on Arntz & Jacob (2016), Edwards (2015), Lobbestael et al. (2007), Young et al. (2013).

## Mode models in personality disorders

### Borderline personality disorder

The mode model was first elaborated on the basis of clinical experience in treating female patients with borderline personality disorder [3, 4] and then extended to patients of both sexes. Young and co-workers [3] identified five major modes characteristic for patients with that personality disorder, with four of them being maladaptive modes: the Abandoned and Abused Child, the Punitive Parent, the Angry and Impulsive Child, and the Detached Protector. In the Abandoned and Abused Child mode, patients often feel pain and terror that are related to most of the schemas, and especially to Abandoning, Harming, Emotional Deprivation, Defectiveness, and Submitting. The dominant feelings include fear, sadness, and the sense of being lost. In this mode, patients feel unloved, unimportant, lonely, helpless, and sensitive to harm. The second mode – the Angry and Impulsive Child – is activated because of unfulfilled core needs. In this case, patients feel anger, or even rage, which is difficult to control. That is why they shout and attack a person they perceive responsible for those emotions. They behave in a demanding and aggressive way, they sometimes threaten to commit suicide. They also act impulsively to fulfil their needs.

The Punitive Parent mode is often an internalised voice of a parent who criticises and punishes the patient, though sometimes it reminds a combination of some difficult persons from their childhood [3, 12, 13]. It is often activated when patients allow themselves to feel or express their needs. The voice is very tough and merciless, and patients in this mode often become their own persecutors. They are full of contempt and hate for themselves, they hurt themselves by mutilating, starving, fantasising about suicide, and behaving in self-destructive ways.

The mode in which patients with borderline personality disorder function most of their time is the one called Detached Protector. In this mode, patients cut off from their needs and emotions, they break bonds with other people or surrender to avoid punishment. The behaviour displayed in this mode often seems healthy – these patients do not lose control, they seem to be in contact with the therapist, they behave according to the therapist's expectations. It looks like they are 'resting' in this mode from overwhelming emotions. However, the real feelings that are experienced while functioning in this mode include the sense of emptiness, depersonalisation, cutting off from reality, boredom. Moreover, they sometimes overuse psychoactive substances in order not to feel overwhelming emotions. In the majority of patients with this disorder, there also occurs the Healthy

Adult mode, yet it is usually underdeveloped, especially at the beginning of therapy. These patients lack a parental mode that would express concern, soothing, and care for the Abandoned Child. This results in the fact that people with borderline personality disorder experience the Abandoned Child so intensively and react to parting with significant others very emotionally.

The functioning of a person with borderline personality disorder is often like being in a vicious circle. A patient may express a need from the level of the Abandoned Child, then he may switch to the Punitive Parent mode to punish himself for having expressed the need, and then he may switch to the Detached Protector mode so as to avoid the overwhelming emotions that have been evoked by the punishment. The Detached Protector and Punitive Parent modes suppress most of his needs and feelings and, thus, strengthen the feelings related to the Abandoned Child mode. This leads to the growth of inner tension and pain until the time when a certain conflict situation with a person who is important for the patient results in extreme tension and the patient switches to the Angry Child mode and starts attacking others. This, in turn, may activate again the mode of the Punitive Parent, who is to punish for the harming behaviour, and next the Detached Protector mode.

The mode model for borderline personality is one of the models that have been best examined regarding the effectiveness of model-based therapy. On the basis of the model proposed by Young and co-workers [3], also the notional model of borderline personality disorder and the model of treatment of this disorder have been elaborated [12].

## Narcissistic personality disorder

Young and co-workers [3] describe three major modes that occur in persons with narcissistic personality disorder: the Lonely Child, Self-Aggrandiser, and Detached Self-Soother/Self-Stimulator. Most patients with narcissistic personality disorder feel like a Lonely Child, who is acknowledged only when and only for what may contribute to pride of their parents. In this mode, patients feel unloved and unworthy of love, they feel sadness, emptiness, and loneliness, and sometimes even contempt to themselves. Feelings in this mode are so difficult for patients that they often do not admit their existence and when they experience those feelings, they try to switch to another mode as fast as possible. They think that what they have managed to achieve in their life is, in fact, beyond their capacities and they have been simply extremely lucky. They think they have deceived all people around and that is why they defend this part from access. The Lonely Child mode becomes usually activated when patients lose a source of the sense of being important or a high position they used to have.

The mode of the Self-Aggrandiser is often an outcome of excessive compensation of the contents resulting from Emotional Deprivation and Defectiveness. As the Lonely Child feels unworthy and defective, in the mode of Self-Aggrandiser, patients strive to show and prove their

superiority by means of both self-idealisation and devaluation of others. They behave in a demanding way, they compete, extol themselves, and criticise others. They react with anger to any signals of lack of acknowledgement or to criticism. They strive to reach a higher position and to decide about everything. According to Young and co-workers [3], the most frequent patterns of behaviour are as follows: aggression and hostility when someone does not want to meet their expectancies or questions their compensation methods; dominance and insistent getting one's own way in order to intimidate others and maintain control over a situation (especially in those situations in which there are activated the schemas of Emotional Deprivation or Defectiveness); aspiring for acknowledgement and status, which are displayed in attaching a lot of weight to high social position, high achievements, appearance, or wealth; and manipulation and abuse when patients use others to get their own gratifications, which they sometimes do without any scruples. According to Young and co-workers [3], some persons with narcissistic personality disorder, called 'hidden narcissists', display the mode of Self-Aggrandiser only in their imagination. In behaviour, they seem inconspicuous and caring about being accepted mainly, yet in fantasy, they dominate others, imagine themselves as being exceptional, filling others with admiration, and having some extraordinary talents.

The third of the modes – the Detached Self-Soother mode – is usually activated in loneliness when patients are deprived of admiration signals from others and they start to experience feelings related to the Lonely Child mode. This mode is a way of cutting off from the pain of the Lonely Child and – depending on the situation – it may be displayed either in undertaking activities that are aimed at providing some stimulation (*e.g.* gambling, races, watching pornography, workaholism) or in becoming engaged in compulsive activities that aim at soothing and distracting attention from the pain of the Lonely Child (*e.g.* watching TV, playing computer games, overeating).

Arntz and Jacob [14] enrich the model with two additional modes: the exceptionally Demanding Parent and the Enraged Child. The Demanding Parent mode reflects excessive expectations of a child, unreasonable standards that the child was to meet, hopes for the child's high position and achievements, and sometimes even parental unrealistic fantasies that their child would become a great and significant person. The Enraged Child mode becomes activated when someone evokes the patient's failure-related emotions or touches some issues that are linked to the Vulnerable Child mode. In such a situation, patients fall into a 'narcissistic rage' and lose control over their emotions and aggression. They attack and humiliate their interlocutors. They try to protect themselves from experiencing shame and the sense of being abandoned, which is usually hidden under the sense of failure [15].

On the basis of the modes distinguished by Young, Wendy T. Behary has elaborated the model of working with patients with narcissistic personality disorder [16–18]. The author

distinguishes varied subtypes of narcissistic personality and indicates a possible differentiation in modes, which depends on the dominating schemas in a person.

### Histrionic personality disorder

Patients with histrionic personality disorder are mainly characterised by the modes of the Vulnerable Child, Impulsive and Undisciplined Child, Attention Seeker, and the Punitive Parent mode [14]. Moreover, descriptions of the Vulnerable Child mode made by Lobbestael and co-workers [15] contain also the Ignored or Humiliated Child.

In the Vulnerable Child mode, patients feel unloved, lonely, abandoned, helpless, and needy. Similarly to patients with borderline personality disorder, also those with histrionic personality disorder have experienced numerous traumas and had sadistic parents, which may be the reason for the Humiliated Child mode. As most of their core needs were not fulfilled in their childhood, the patients look for attention, acknowledgement, and admiration, and they are ready to do everything to get them. Moreover, they have low tolerance for frustration and difficulties in self-discipline. When they feel unimportant, useless, or when a task they are realising is boring, they switch to the Impulsive and Undisciplined Child mode. They act impulsively, without thinking, which may often lead to consequences that activate the Punitive Parent mode. In this mode, patients with histrionic personality disorder devaluate themselves – they perceive themselves as inadequate, unattractive, worthless, stupid, and lazy. However, the major mode of coping is the Attention Seeker. In this mode, patients are ready to do everything to gain attention for their lost and emotionally deprived child modes. They present typical histrionic behaviours, such as dramatizing, exaggerating, and excessive sexualisation of behaviours. The emotions they express seem artificial and diminish fast.

However, the presence of the distinguished modes is not confirmed in all studies. For instance, Bamelis and co-workers [10] have found confirmation for the Attention Seeker only. This may be explained by the dominant over-compensatory mode, which is aimed at denying the contents of the schemas and keeping painful modes beyond consciousness [19]. Similar mechanisms are also observed in people with antisocial, narcissistic, and obsessive-compulsive personality disorders [10].

### Avoidant personality disorder

In patients with avoidant personality disorder, usually five modes are distinguished: the Lonely and Inferior Child, the Abandoned and Abused Child, the Punitive Parent, the Avoidant Protector, and the Detached Protector [10, 14, 20]. Lobbestael and co-workers [15] add also the Compliant Surrender mode, which occurs in some of the patients.

The main problem in avoidant personality disorder lies in child modes. The Lonely and Inferior Child mode represents the emotional state that patients try to avoid, the one in which they feel again loneliness and inferiority which they experienced in childhood. The Abandoned and Abused Child mode represents the emotional state that the patients experienced in their childhood when they were maltreated or abandoned by their parents or other significant persons. The Punitive Parent mode reflects an internalised insulting and humiliating parental voice. This mode often evokes an intense sense of guilt and shame. The occurrence of these modes is also confirmed in studies on relations between parental behaviours and the development of personality disorders. Avoidant personality disorder is related to a high level of abuse and maltreatment in childhood [21]. Its development is also influenced by the lack of parental love, care, and attachment [22].

In order to cope with the feelings of being abandoned, humiliated, and inferior, patients utilize avoidant modes, which help to find a distance from their own needs. The Avoidant Protector mode is characterised by avoiding certain situations, and the Detached Protector mode is characterised by avoiding difficult emotions, thoughts, inner needs, and also emotional closeness with others. Some of the patients use the Compliant Surrender mode, which reflects their typical patterns of compliant behaviours. In this mode, patients submit to the needs and ideas of others and, thus, they avoid conflicts, punishment, or taking responsibility [15].

## Dependent personality disorder

Dependent personality disorder may regard both functional dependence (when a patient has difficulties with self-dependent everyday functioning) and emotional dependence (when a patient manages to cope in life but desperately needs someone to get emotional support from) [23]. The aetiology of dependent personality disorder includes authoritative parental style, overprotectiveness of a parent [20], and emotional abuse of a child [21].

In dependent personality disorder, four dominant modes are indicated in literature [10, 14, 15, 20]: the Dependent Child, the Abandoned and Abused Child, the Punitive Parent, and the Compliant Surrender. In the Dependent Child mode, patients feel overburdened with adult life demands and they fall in panic when others are not available, do not support them, or do not take responsibility for them. Patients in this mode have a sense of inability to cope with everyday matters alone. Patients with dependent personality disorder sometimes display also the Abandoned and Abused Child mode, especially if the dependence concerns the emotional sphere (in this case, the feeling of being abandoned and a strong fear of becoming abandoned are dominating), or when the patient experiences emotional abuse known from childhood once more. The Punitive Parent mode is a source of the sense of guilt when a patient puts his/her needs first (as it is the case in avoidant personality disorder). This mode becomes activated when patients make self-dependent

decisions or try to broaden and develop their autonomy. The main mode to cope with the demands from the Punitive Parent, who does not accept autonomous behaviours of a child and punishes for autonomy and self-dependence attempts, is the Compliant Surrender mode. In this mode, patients agree with the opinions of others, meet their expectations, and give up their own autonomy because of their fear of not coping or being abandoned.

### Obsessive-compulsive personality disorder

According to Arntz [20], obsessive-compulsive personality disorder – similarly to other cluster C personality disorders – is often related to the experience of emotional abuse in childhood. It is also influenced by cold and exacting parental style, high standards in the area of achievements, burdening a child with excessive responsibility, and treating emotions as unimportant.

The typical modes that are attributed to patients with obsessive-compulsive personality disorder include as follows [14, 19, 20]: the Vulnerable Child (most often the Lonely Child), the Demanding and/or Punitive Parent, the Perfectionist Over-Controller, and the Self-Aggrandiser. The Vulnerable/Lonely Child mode is often invisible at the beginning of therapy. This often results from the emotional entanglement that a patient has experienced in childhood and from having been punished for expressing the need for autonomy. The Demanding and/or Punitive Parent mode reflects very high demands that a patient experienced in childhood and punishments he/she experienced for being unable to meet them. The basic and very distinct way of coping is the Perfectionist Over-Controller mode. This mode is a direct answer to the demands of parental modes and is treated as a survival strategy. It is aimed at avoiding all types of mistakes and failures. Depending on personal experiences, patients in this mode may demand a lot from themselves, strive for perfection, be excessively economical, focus too much on details, strive excessively to maintain control. Most persons with obsessive-compulsive personality disorder display also the Self-Aggrandiser mode. This mode is based upon a patient's belief that perfectionism and high achievements would allow her/him to predominate morally over other people, who are perceived as less reliable, less scrupulous, less industrious. In this way, the patient feels better than others and, thus, denies the inner sense of being not good enough [24, 25].

### Antisocial and psychopathic personality disorder

A number of studies have been devoted to adapting the mode model for criminal patients [8, 9]. According to Bernstein and co-workers [8], persons with antisocial personality may switch among the following modes: the Detached Protector (when they detach from their emotions), the Self-Soother (when they try compulsively to soothe their emotions using alcohol, drugs, or other substances), the Angry Child (when they react in primitive ways to signals of being abandoned or to

the activation of a narcissistic wound), the Self-Aggrandiser (when they extol themselves and devaluate others), the Conning and Manipulative mode (when they deceive and manipulate others), or the Predator mode (when they try to eliminate a threat, a rival, or a difficulty and they do it with premeditation and aggression).

Keulen-de Vos and co-workers [9] distinguish ten maladaptive modes in patients with psychopathic personality disorder: the Vulnerable Child, Angry Child, Impulsive Child, Detached Protector, Angry Protector, Detached Self-Soother, the Bully and Attack mode, Predator, Self-Aggrandiser, and the Conning and Manipulative mode. The events that precede an act of violence often evoke painful emotions which result from childhood experiences, when patients felt abandoned, lonely, and harmed. Activation of child modes (*e.g.* the Abandoned and Abused Child) activates the style of coping (which is most often related to experiencing anger and aggression), so as to manage with these difficult emotions and a former perpetrator.

According to the authors [8, 9], persons with antisocial and psychopathic personality disorders gain notable benefits from their maladaptive modes of coping: the Predator, the Conning and Manipulative mode, the Self-Aggrandiser, and the Bully and Attack mode. Furthermore, the authors emphasize that the Predator mode, which is related to psychopathy most of all, develops in childhood under the influence of an extreme threat or humiliation experienced by a child. They also stress that it is highly probable that this mode was dominant in the behaviours of some significant persons in the child's surrounding and it was presented to the child as a valuable and effective way of coping.

## Conclusion

The models that have been elaborated on the basis of clinical practice are being verified in numerous empirical studies [26, 27] and they serve to create schemes of therapy. Working based on the Mode Model is the preferred form of treatment for persons with severe personality disorders by therapists working in this approach [3, 8, 14, 17, 20]. It is referred to as an integrative part of schema therapy, which is combined smoothly with typical working with schema. It comprises a number of techniques that let a therapist work with the quickly changing emotional states of patients and with the strategies of coping that are characteristic of particular personality disorders. Therapies based on the mode model usually consist in strengthening of the Healthy Adult mode, reducing parental modes, making maladaptive coping modes characteristic of a given disorder more flexible, and replacing them with more healthy and adaptive strategies of coping [3, 6, 14, 19].

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E-mail address: mariafinogenow@op.pl