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DEVELOPMENT AND VALIDATION OF THE POLISH EXPERIMENTAL SHORT VERSION OF THE YOUNG SCHEMA QUESTIONNAIRE (YSQ-ES-PL) FOR THE ASSESSMENT OF EARLY MALADAPTIVE SCHEMAS

The Young Schema Questionnaire (YSQ) measures the intensity of early maladaptive schemas connected with symptoms of mental disorders, particularly personality disorders. We conducted a procedure of shortening the Polish version of the YSQ, analogous to the original one, and determined the psychometric properties of the instrument thus developed by performing a reliability and validity analysis (n = 1.073). In the second part of the study we tested the factor structure of the YSQ using confirmatory factor analysis in the sample from Study 1 and an independent group (n = 898). We reduced the number of items in the questionnaire from 232 to 90 – leaving five items in each of the 18 scales corresponding to specific schemas. We obtained adequate and high internal consistency coefficients for each subscale and for the whole instrument. The overall meas-

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ure of schemas was positively associated with beliefs characteristic for all personality disorders measured by the Personality Beliefs Questionnaire (PBQ). The intensity of the schemas (except the *Self-Sacrifice* scale) significantly differentiated participants from the clinical (n = 31) and nonclinical groups (n = 1,042). We also confirmed the theoretical factor structure of the instrument, although the weakness of some measures of fit suggests the need for further research. The obtained results support the use of the experimental short Polish version of the Young Schema Questionnaire as a measure of early maladaptive schemas.

Keywords: Young Schema Questionnaire; YSQ; early maladaptive schemas; psychometric analysis; factor structure; personality disorders; schema therapy.

INTRODUCTION

The Young Schema Questionnaire (YSQ) is an instrument measuring the intensity of early maladaptive schemas, one of the central theoretical constructs underlying schema therapy[1].

A cognitive schema, defined by Beck as a cognitive structure, "a basis for screening out, differentiating and coding the stimuli that confront the individual" (Beck, 1967, p. 13) or a stable aspect of the individual's cognitive functioning, providing a system for the classification of stimuli is a fundamental concept in cognitive psychopathology. Beck's theory is referred to by some authors (Wells, 1997, as cited in Stopa & Waters, 2005) as schema therapy, since the contents (e.g., automatic thoughts) and cognitive operations (distortions) are manifestations of a cognitive schema. An implication of this assumption is the focus on identifying and modifying dysfunctional schemas in the process of cognitive therapy.

Jeffrey Young, Beck's student and collaborator for many years, elaborated the schema theory and the form of psychotherapy based on it (Young, Klosko, & Weishaar, 2014). The approach whose assumptions he formulated integrates cognitive behavioral therapy with psychodynamic and humanistic approaches, particularly with John Bowlby's attachment theory and his Gestalt therapy (Young, Klosko, & Weishaar, 2014). Empirical studies provide more and more data confirming the effectiveness of schema therapy in the treatment of personality disorders, with special emphasis on borderline personality disorder (Bamelis, Evers, Spinhoven, & Arntz, 2014; Bernstein et al., 2012; Farrell, Shaw, & Webber, 2009; Giesen-Bloo et al., 2006; Nadort et al., 2009; Nordahl & Nysæter, 2005).

[1] The term *schema therapy* has been approved by the International Society of Schema Therapy (cf. Edwards & Arntz, 2012). Initially, Jeffrey Young proposed the term *schema-focused therapy*, which is still used in some empirical papers (cf. Farrell, Shaw, & Webber, 2009).

According to Young, an early maladaptive schema is one of the "broad, pervasive themes regarding oneself and one's relationship with others, developed during childhood and elaborated throughout one's lifetime, and dysfunctional to a significant degree" (Young & Behary, 1998, p. 345). In this approach, schemas comprise not only beliefs but also memories, emotions, and bodily sensations. The link between early maladaptive schemas and various manifestations of disorders, particularly personality disorders, has been confirmed in empirical studies (cf. Nordahl, Holthe, & Haugum, 2005; Petrocelli, Glaser, Calhoun, & Campbell, 2001; Reeves & Taylor, 2007). According to the biosocial model, the etiology of EMS is attributed to the interaction of temperamental factors and the influence of the environment. The latter refers, above all, to the role of inadequate satisfaction of basic emotional needs regarding early childhood relationships with significant others (Arntz & van Genderen, 2009; Young, Klosko, & Weishaar, 2014). The activation of schemas involves the experience of specific emotional states and with the activation of coping strategies (Jacob & Arntz, 2013). These reactions are usually part of the schema maintenance mechanism, impeding the spontaneous change of schemas.

The original list of schemas was based on Young's (1994) clinical experience. The current model is a hierarchical structure of 18 schemas grouped into five domains, hypothetically associated with specific basic emotional needs met inadequately (Table 1)[2].

The YSQ is currently the most widely used instrument for assessing early maladaptive schemas, both in clinical practice and in research[3]. Two main versions are in use: long (YSQ-L) and short (YSQ-S). Originally, the questionnaire consisted of 205 items relating to 16 schemas (Young, 1994). The short version was prepared based on the results of principal component analysis (PCA) by the selection of five items with the highest loadings for each of the 16 scales (Schmidt, Joiner, Young, & Telch, 1995). The latest long version, YSQ-L3, consists of 232 items, and the short one, YSQ-S3, has 90 items grouped into 18 scales corresponding to specific schemas (Young et al., 2014). Empirical studies

[2] In recent years, the popularity of Schema Therapy has been growing in Poland. Translations of the main books on this subject have been published – with several Polish equivalents of terms fundamental to the schema theory, such as the names of schemas and domains. The Polish translations we propose in the present article are based on linguistic consultations and terms functioning in clinical practice. In Appendix, we provide the main English terms and their most frequent translations taken from books published in Polish. We hope this will help organize the diverse Polish-language terminology in this field.

[3] Some authors (cf. Sheffield & Waller, 2012) underline that YSQ items refer rather to beliefs (cognitions) related to schemas rather than to schemas *per se*.

showed that the YSQ was a diagnostic instrument characterized by high internal consistency and acceptable test-retest stability (Oei & Baranoff, 2007). The YSQ makes it possible to distinguish between individuals from the clinical and non-clinical groups (Rijkeboer, van den Bergh, & van den Bout, 2005). The psychometric properties of the YSQ justify the use of the questionnaire for research and clinical purposes. So far, the verification of the factor structure of the YSQ has yielded ambiguous results for the second-order factors (areas), but it has fairly consistently confirmed the fit of the 18-factor model. The short version has been shown to have psychometric properties comparable to the long version (Stopa, Thorne, Waters, & Preston, 2001; Waller, Meyer, & Ohanian, 2001).

Table 1
Early Maladaptive Schemas, Schema Domains, and the Corresponding Needs

Domains	Needs	Schemas
Disconnection and Rejection	Secure bond, acceptance, protection	*Emotional Deprivation* *Abandonment / Instability* *Mistrust / Abuse* *Social Isolation* *Defectiveness / Shame*
Impaired Autonomy and Performance	Autonomy, competence, identity	*Failure to achieve* *Dependence / Incompetence* *Vulnerability to Harm or Illness* *Enmeshment / Undeveloped Self*
Impaired Limits	Realistic limits, self-control	*Entitlement / Grandiosity* *Insufficient Self-Control / Self-Discipline*
Other-Directedness	Free expression of needs and emotions	*Subjugation* *Self-Sacrifice* *Approval-Seeking / Recognition-Seeking*
Overvigilance and Inhibition	Spontaneity and play	*Emotional Inhibition* *Unrelenting Standards / Hypercriticalness* *Negativity / Pessimism* *Punitiveness*

The results of psychometric analyses of 10 language versions of YSQ-S3 have been published to date, from various cultures. These studies confirmed the convergent and discriminant validity, high overall-scale reliability, and acceptable test-retest stability (cf. Bach, Simonsen, Christoffersen, & Kriston, 2017). The internal consistency of the scales corresponding to particular schemas re-

mained at the level of Cronbach's $\alpha > .70$, except for individual dimensions in some language versions.

According to information available iat the time of preparation of this manuscript, Polish adaptation of the short version of YSQ (in the form being a direct translation of the original YSQ-S3) is going to be published soon (Oettingen, Chodkiewicz, Mącik, & Gruszczyńska, in press). As far as we know, the Polish version of the YSQ has been used in several published studies (cf. Besta, Barczak, Lewandowska-Walter, & Dozois, 2014; Mącik, 2016). No attempts have been made, however, to develop a Polish short YSQ based on the long version. The aim of the present paper is to supply the missing empirical knowledge in this respect, particularly in the context of the increasingly widespread use of schema therapy in clinical treatment of personality disorders in Poland.

The presented study consisted of two parts. In the first one (Study 1) we performed a procedure of shortening the YSQ to 90 items, preserving its psychometric properties and theoretically postulated factor structure. We adopted high internal consistency (Cronbach's $\alpha > .80$) as an indicator of reliability. Based on theoretical assumptions and earlier results, we expected the validity test to yield positive correlations between the intensity of schemas and beliefs characteristic for specific personality disorders. We expected significantly higher scores on YSQ scales in the clinical sample compared to the nonclinical sample (Bach et al., 2017; Rijkeboer et al., 2005). In the second part of the study (Study 2), we verified the adopted solution using confirmatory factor analysis.

METHOD

Samples

Study 1 was conducted on a mixed sample (N = 1,073) composed of individuals from the general and clinical populations, recruited by random sampling (n = 709, 66.1%) and by inviting postgraduate students of the Cognitive Behavioral Therapy School of the SWPS University (n = 63, 5.9%). Additionally, we analyzed the scores of 270 (25.2%) participants in traffic accidents, examined in the research project "PTSD: Diagnosis, Therapy, Prevention" (PTSD-DTP) – *TRAKT-3*. The clinical sample was individuals undergoing treatment for anxiety, depressive disorders, and personality disorders, diagnosed by a psychiatrist at the Psychotherapy Center of the Medical University of Warsaw (n = 31, 2.9%). Due to the lack of access to medical documentation, it was not possible for the pur-

pose of the study to establish the exact characteristics of this group in terms of psychiatric diagnosis.

The participants in Study 2 were 898 individuals taking part in the main study of the project *PTSD-DTP – TRAKT-3*. In this sample, 33.2% were people who had been in a traffic accident (n = 298), 33.2% were firefighters in active service (n = 298), and 33.6% were flood victims (n = 302; the data of six individuals who did not complete the YSQ were excluded).

The data used in the present paper had been obtained in measurements performed on a direct-contact basis (by means of the paper-and-pencil method) in 2012-2015. All the subjects took part in the study on a voluntary basis, and both studies were approved by the local committee for research ethics.

The demographic characteristics of the participants in Study 1 (divided into the clinical and nonclinical groups) and in Study 2 are presented in Table 2.

Table 2
Characteristics of Samples in Studies 1 and 2

	Study 1			***Study 2***
Demographic characteristics	Whole sample	Clinical sample	Nonclinical sample	Whole sample
N	*n* = 1073	*n* = 31	*n* = 1042	*n* = 898
Gender; *N* (%):				
Female	610 (56.8)[#]	24 (77.4)	586 (56.2)	339 (37.8)
Male	460 (42.9)	7 (22.6)	453 (43.5)	559 (62.2)
Age; mean (*SD*)	31 (13.7)	30.9 (7.0)	31.0 (13.9)	39.2 (13.2)
Education; *N* (%):				
higher	555 (51.7)[##]	18 (58.1)	537 (51.5)	306 (34.1)
secondary	283 (26.4)	13 (41.9)	270 (25.9)	452 (50.3)
basic vocational	221 (20.6)	–	221 (21.2)	106 (11.8)
elementary	10 (0.9)	–	10 (1)	34 (3.8)

Note. # – in the case of three participants in the study, we obtained no information about gender; ## – in the case of four participants in the study, we obtained no information about education level.

Measures

The participants in Study 1 completed the questionnaire that was a Polish translation of the long version of the original Young Schema Questionnaire

(YSQ-L3). It consists of 232 items grouped into 18 scales corresponding to specific early maladaptive schemas (cf. Table 1). Each of the scales consists of 9 to 17 items. The overall scale was also generated, consisting of the whole set of 232 items. In accordance with the adopted response format, the participants rated each item on a 6-point Likert scale (from 1 – *completely untrue of me*, to 6 – *describes me perfectly*). In accordance with the adopted standards, the original version of YSQ-L3 was independently translated into Polish by two people aware of the theoretical and clinical background of the questionnaire (a psychologist and a consultant psychiatrist). Next, we applied the back-translation procedure. Selected items from both versions of the translation were additionally compared with the translation done independently by Justyna Oettingen from the Jagiellonian University[4]. We found no significant differences in content between the two versions. In Study 2, we used the version of the YSQ consisting of 90 items (five in each scale), prepared in accordance with the procedure described further in this article.

When testing validity (only in the group of participants in accidents, $n = 270$), we also used the Personality Beliefs Questionnaire (PBQ), which is based on the cognitive theory of personality disorders (Beck et al., 2001) and has been described in detail in the current issue (Zawadzki, Popiel, Pragłowska, & Newman, 2017).

DATA ANALYSIS PROCEDURE

Study 1

The procedure of shortening the instrument was applied, as in the case of YSQ-S (Schmidt et al., 1995), with the use of PCA on data from the whole sample ($N = 1{,}073$). In accordance with the theoretical assumptions of the model of schemas, we forced a solution with 18 components. In view of the intercorrelation of some components (Pearson's $r > .32$), we used nonorthogonal *Oblimin*

[4] In our study we used the Polish translation of the YSQ-L3 made a few years before the beginning of the study, based on the consent given by Jeffrey Young to the second author of this paper. During the final stage data collection we obtained information from the author that an independent authorized translation, by Justyna Oettingen, was in preparation. The version used in our study was thus acknowledged as experimental, intended to be used exclusively for research purposes in the PTSD: DTP project.

In order to obtain Polish versions of the YSQ, one should contact Justyna Oettingen – the author of the current Polish version of the YSQ.

rotation (Tabachnick & Fidell, 2013). We performed the procedure on ipsatized data first in order to weaken the principal component and facilitate the interpretation of the solution (Baron, 1996). We removed the items: (a) with the lowest loadings (below .40), (b) loaded by components interpreted as other than those postulated in the original version, (c) loaded by more than one component if the second factor loading was higher than .20. Due to the instability of the solution for components corresponding to the *Negativity/Pessimism* and *Punitiveness* schemas, we left all items in these scales at this stage. Thus, we obtained 165 items, which we subjected to the same procedure again, this time using more conservative criteria: we retained items with loadings above .40-.65 (flexibly, depending on the stability of the solution and the number of question in a given scale). We obtained 111 items (from 5 to 7 per scale) in a stable factor solution. Next, we performed a correction of the adopted solution on raw data. On this basis, we obtained the final set of 90 items and 18 components, interpreted as measures of the levels of specific schemas described by Young. In order to verify the solution, we performed exploratory factor analysis using principal axis factoring (PAF) with *Oblimin* rotation on raw data. To determine the optimal number of factors, we adopted the Kaiser criterion of eigenvalue higher than 1.

Due to the small size of the clinical sample ($N = 31$), we performed reliability analysis for the long version and the two short versions on data obtained from the whole sample. We computed Cronbach's α coefficients for the overall scale and for the 18 subscales, as well as corrected item-total correlations for each scale. To verify the convergent and discriminant validity of the measure, we computed correlations (Pearson's r coefficients) between YSQ and PBQ scales ($n = 270$). In order to preserve the clarity of the presented results, in this article we present only the correlations obtained for the overall YSQ scale (the data for the 18 subscales are only discussed). We also checked if the subjects from the clinical sample scored significantly higher on the 18 YSQ scales than those from the nonclinical sample (one-factor ANOVA).

Study 2

Next, we tested the factor structure of the short version using confirmatory factor analysis, comparing the 18-factor solution (corresponding to scales measuring the 18 schemas described by Young) with the one-factor solution (the general scale comprising all the items of the questionnaire) and with a hierarchical model assuming a higher-order factor and 18 lower-order factors. We per-

formed the analyses on data obtained for an independent sample (n = 898) in comparison to Study 1 sample (n = 1,073).

We used a maximum likelihood estimator resistant to the nonfulfilment of the assumptions of multidimensional normal distribution: MLR. This allowed for obtaining corrected chi-squared statistics (χ^2), asymptotically equivalent to Yuan-Bentler's T-2 statistic with an asterisk (T2*), using an approach based on the generalized least squares method (Rosseel, 2012; Yuan & Bentler, 2000). To determine robust standard errors, we used the Huber–White estimator. The MLR procedure made it possible to use all observations in the analysis, including the 128 (14.3%) that had contained missing data (0.6%). To estimate the missing values, we applied the full information maximum likelihood (FIML) estimator.

In accordance with the standards (Jackson, Gillaspy, & Purc-Stephenson, 2009), we used several general measures of fit in order to assess the fit of the model to the data: corrected chi-square (χ^2), chi-square divided by the number of degrees of freedom (χ^2/df), comparative fit index (CFI), adjusted goodness of fit index (AGFI), root mean square error of approximation (RMSEA), and standardized root mean square residual (SRMR). We adopted the following boundary values interpreted as approximate indices of good (in parentheses: acceptable) model fit: CFI $\geq$ .97 (.95), AGFI $\geq$ .90 (.85), RMSEA $\leq$ .05 (.08), SRMR $\leq$ .05 (.10) (Schermelleh-Engel, Moosbrugger, & Müller, 2003). Local fit of the 18-factor was analyzed based on the values of factor loadings, the reliability of the loadings (*omega* coefficient), and average variance explained (AVE).

Statistical analyses were performed by means of SPSS 23 (IBM Corp., Armonk, NY) and lavaan statistical packages, in the R environment (R Development Core Team, 2015; Rosseel, 2012).

RESULTS

Short version development

Using principal component analysis, we selected 90 out of the questionnaire's 232 items based on the highest loadings on the respective 18 components (interpreted as scales corresponding to specific EMS). The 90-item set (YSQ-ES-PL) contained 56 items that were also included in the original short version (62.2%) and 34 from the remaining pool of items of the long version. They explained 66% of the total variance. We tested this solution by performing an exploratory factor analysis using the principal axis method. The Kaiser criterion

supported the extraction of 18 factors corresponding to particular scales and together explaining 59% of variance. The factor loadings, lower than those obtained in PCA, exceeded .50 for most items (except for 10 of them) in the short version of the scales. The loadings of items 46 (-.31; item 118 in YSQ-L3) and 50 (-.26; item 123 in YSQ-L3) in the *Subjugation* scale were below the acceptable level (≤ .40). We obtained the highest component loading for the *Emotional Deprivation* scale (-.72 to -.89) and the lowest for *Subjugation* (-.26 to -.67). For the remaining factors corresponding to particular scales, these values were as follows: *Abandonment/Instability* (.40 to .74), *Mistrust/Abuse* (-.56 to -.76), *Social Isolation* (.57 to .85), *Defectiveness/Shame* (.51 to .66), *Failure to Achieve* (.62 to .83), *Dependence/Incompetence* (.51 to .80), *Vulnerability to Harm or Illness* (.44 to .67), *Enmeshment/Undeveloped Self* (.56 to .80), *Self--Sacrifice* (.56 to .66), *Emotional Inhibition* (-.56 to -.66), *Unrelenting Standards/Hypercriticalness* (-.59 to -.70), *Entitlement/Grandiosity* (.41 to .75), *Insufficient Self-Control/Self-Discipline* (-.51 to -.60), *Approval-Seeking Recognition-Seeking* (.41 to .77), *Negativity/Pessimism* (.41 to .71), *Punitiveness* (.52 to .73).

These factors correlated highly with the respective scales of the long version (Pearson's $r > .80$) and the original short version ($r > .90$), except the factor interpreted as the *Subjugation* variable.

The reliability of the scales of the short version

Reliability analysis revealed high (Cronbach's α from .79 to .91) internal consistency of the subscales and the overall scale ($\alpha = .97$) of the short version of the measure (Table 3). The reliability coefficient obtained for the overall scale was equal for the two short versions (the original one and the one developed in accordance with the procedure described in the present paper) and slightly higher for the long version with 232 items ($\alpha = .99$). Internal consistency coefficients for particular subscales of the original version YSQ-S3 ranged from .74 to .91.

Data concerning reliability analysis for YSQ-ES-PL in Study 2 sample are presented in Table 4. The obtained coefficients turned out to be slightly higher than in Study 1. For the overall scale, internal consistency was $\alpha = .98$.

All corrected item-total correlations for the newly developed short version of YSQ in Study 1 sample were above the acceptable minimum of .40.

Table 3

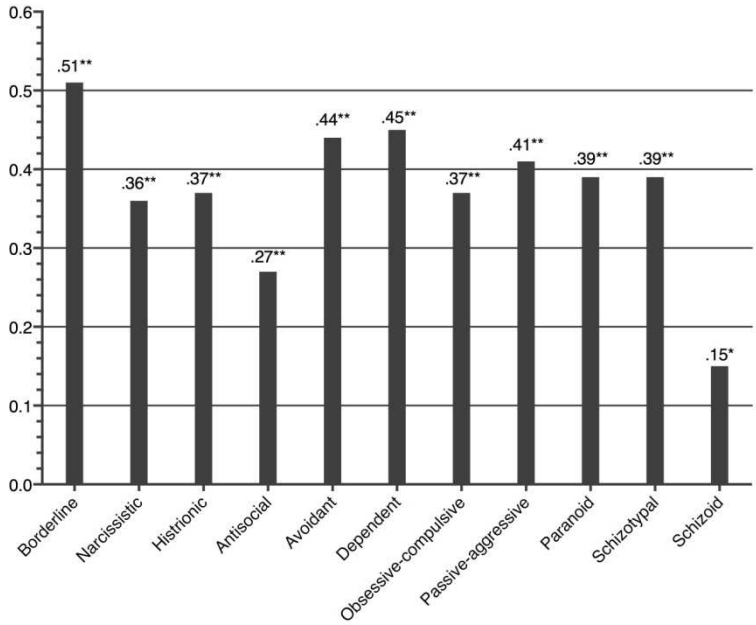
Comparison of Means, Standard Deviations, and Reliability Coefficients (Cronbach's α) for Study 1 Sample for Three Versions of the Young Schema Questionnaire: Long (YSQ-L3), Short Consisting of the Original Items (YSQ-S3), and Shortened by Means of the Procedure Described in the Present Paper (YSQ-ES-PL)

	YSQ-L3				YSQ-S3				YSQ-ES-PL			
Scale	N_i	*M*	*SD*	α	N_i	*M*	*SD*	α	N_i	*M*	*SD*	α
ED	9	2.11	1.06	**.93**	5	2.11	1.08	**.88**	5	2.06	1.11	**.91**
AB	17	2.21	0.94	**.92**	5	2.34	1.12	**.83**	5	2.37	1.16	**.84**
MA	17	2.33	0.90	**.92**	5	2.33	1.04	**.82**	5	2.76	1.17	**.87**
SI	10	2.05	1.04	**.91**	5	2.13	1.14	**.86**	5	2.01	1.18	**.91**
DS	15	1.78	0.82	**.92**	5	1.66	0.94	**.90**	5	1.65	0.94	**.89**
FA	9	2.03	1.02	**.93**	5	1.98	1.07	**.91**	5	1.98	1.07	**.91**
DI	15	1.84	0.84	**.93**	5	1.72	0.84	**.82**	5	1.88	1.00	**.88**
VU	12	1.98	0.90	**.90**	5	1.89	0.97	**.82**	5	1.93	0.97	**.81**
EU	11	1.86	0.86	**.90**	5	1.87	0.95	**.82**	5	1.94	1.00	**.82**
SB	10	2.07	0.88	**.88**	5	1.96	0.93	**.81**	5	1.94	0.93	**.83**
SS	17	3.01	0.91	**.90**	5	3.00	0.99	**.74**	5	3.47	1.07	**.79**
EI	9	2.30	1.04	**.89**	5	2.18	1.14	**.89**	5	2.18	1.14	**.89**
US	16	2.74	1.00	**.92**	5	2.92	1.13	**.79**	5	2.69	1.19	**.86**
ET	11	2.55	0.93	**.87**	5	2.39	1.03	**.81**	5	2.34	1.02	**.80**
IS	15	2.48	0.96	**.91**	5	2.57	1.12	**.84**	5	2.57	1.12	**.84**
AS	14	2.45	0.93	**.91**	5	2.67	1.05	**.79**	5	2.63	1.12	**.85**
NP	11	2.42	1.08	**.92**	5	2.45	1.20	**.88**	5	2.52	1.20	**.87**
PU	14	2.56	0.93	**.90**	5	2.32	0.97	**.81**	5	2.50	1.09	**.85**
Overall	232	2.29	0.69	**.99**	90	2.25	0.70	**.97**	90	2.30	0.70	**.97**

Note. YSQ scales: ED – *Emotional Deprivation*, AB – *Abandonment/Instability*, MA – *Mistrust/Abuse*, SI – *Social Isolation/Alienation*, DS – *Defectiveness/Shame*, FA – *Failure to Achieve*, DI – *Dependence/Incompetence*, VU – *Vulnerability to Harm or Illness*, EU – *Enmeshment/Undeveloped Self*, SB – *Subjugation*, SS – *Self-Sacrifice*, EI – *Emotional Inhibition*, US – *Unrelenting Standards/Hypercriticalness*, ET – *Entitlemen/Grandiosity*, IS – *Insufficient Self-Control/Self-Discipline*, AS – *Approval-Seeking/Recognition-Seeking*, NP – *Negativity/Pessimism*, PU – *Punitiveness*. N_i – the number of items in the scale; *M* – mean; *SD* – standard deviation, α – Cronbach's alpha coefficient.

The validity the scales of the short version

The results of correlation matrix analysis (Pearson's *r* coefficients) for the overall measure of early maladaptive schemas (overall YSQ-ES-PL score) and all clusters of cognitive beliefs pertaining to specific personality disorders are presented in Figure 1.

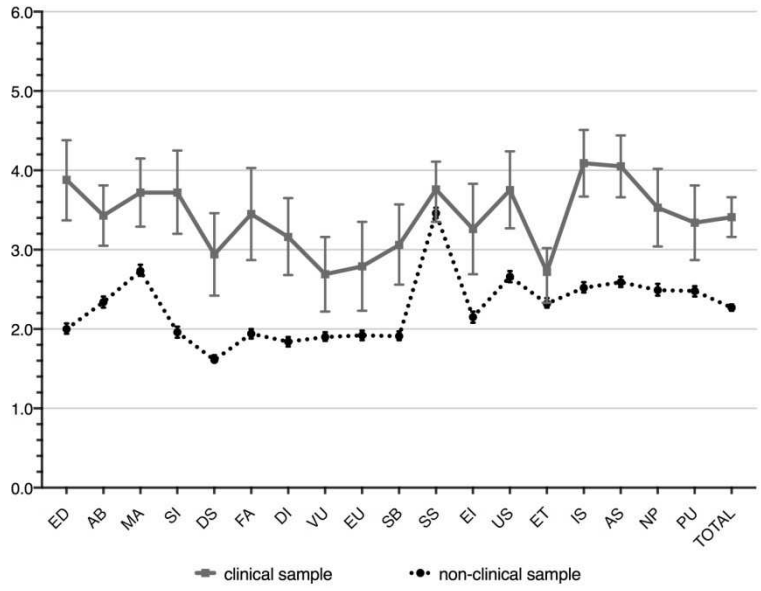


Note. ** correlations significant at $p < .01$ (two-tailed); * correlations significant at $p < .05$ (two-tailed).

Figure 1. Correlations (Pearson's *r* coefficients) of the overall Young Schema Questionnaire (YSQ-ES-PL) scale with the intensity of cognitive schemas characterizing specific personality disorders (measured with the Personal Beliefs Questionnaire, PBQ).

We found the strongest associations for beliefs corresponding to borderline ($r = .51$, $p < .01$), dependent ($r = .45$, $p < .01$), and avoidant personality disorders ($r = .44$, $p < .01$). Correlations with the overall measure of schemas were the weakest in the case of cognitive contents characteristic for schizotypal personality disorder ($r = .15$, $p < .05$). Except the negative relationship of the *Self--Sacrifice* schema with beliefs characteristic for schizoid personality disorder ($r = -.19$, $p < .05$), all the statistically significant correlations between schemas and sets of beliefs were positive (taking into account the Bonferroni correction). Beliefs characteristic for borderline personality disorder were positively asso-

ciated with each of the early maladaptive schemas ($r \geq .27$, $p < .01$) except *Self--Sacrifice* (ns.), being the strongest correlate for 10 of them. They were the most strongly associated with *Dependence/Incompetence* and *Defectiveness/Shame* ($r = .51$, $p < .01$), *Social Isolation/Alienation* ($r = .48$, $p < .01$) and *Failure to Achieve* ($r = .46$, $p < .01$). The *Mistrust/Abuse* scheme was the most strongly correlated with cognitive contents related to paranoid personality disorder ($r = .42$, $p < .01$); *Punitiveness* ($r = .49$, $p < .01$), *Unrelenting Standards/Hypercriticalness* ($r = .34$, $p < .01$) and *Self-Sacrifice* ($r = .21$, $p < .01$) – with contents associated with obsessive-compulsive personality disorder; *Approval-Seeking/ Recognition-Seeking* – with dependent and histrionic personality disorders ($r = .38$, $p < .01$), *Entitlement/Grandiosity* – with narcissistic ($r = .49$, $p < .01$) and passive-aggressive personality disorders ($r = .42$, $p < .01$); and *Enmeshment/ Undeveloped Self* – with schizotypal personality disorder ($r = .37$, $p < .01$).



Note. YSQ scales: ED – *Emotional Deprivation*, AB – *Abandonment/Instability*, MA – *Mistrust/Abuse*, SI – *Social Isolation/Alienation*, DS – *Defectiveness/Shame*, FA – *Failure to Achieve*, DI – *Dependence/ Incompetence*, VU – *Vulnerability to Harm or Illness*, EU – *Enmeshment/Undeveloped Self*, SB – *Subjugation*, SS – *Self-Sacrifice*, EI – *Emotional Inhibition*, US – *Unrelenting Standards/Hypercriticalness*, ET – *Entitlement/Grandiosity*, IS – *Insufficient Self-Control/Self-Discipline*, AS – *Approval-Seeking/Recognition-Seeking*, NP – *Negativity/Pessimism*, PU – *Punitiveness*, TOTAL – overall YSQ-ES-PL score.

Figure 2. Mean scores on the scales of the Young Schema Questionnaire YSQ-ES-PL in the clinical ($N = 31$) and nonclinical samples ($N = 1.042$) with 95% confidence intervals. Intergroup differences (ANOVA) significant at $p < .01$ for all scales except *Self-Sacrifice* (SS) and *Entitlement/Grandiosity* (ET).

As expected, the general level of early maladaptive schemas was significantly higher in the clinical sample (M = 3.41) compared to the nonclinical sample: M = 2.27, $F(1, 1071) = 85.72$, $p < .01$, $\eta^2 = .07$. This difference was statistically significant ($p < .05$) also for all YSQ scales ($F(1, 1071) \geq 4.45$) except *Self--Sacrifice* (ns.). The highest values of effect size were obtained for differences in the levels of *Emotional Deprivation* ($\eta^2 = .08$, $p < .01$) as well as *Social Isolation /Alienation*, *Defectiveness*, *Failure to Achieve*, and *Insufficient Self-Control* ($\eta^2 = .06$, $p < .01$). The mean levels of specific schemas in both groups are presented in Figure 2.

Confirmatory factor analysis of the short version

The results of confirmatory factor analysis on data from Study 1 sample, except the corrected χ^2 statistic, indicate an acceptable or even good fit of the 18-factor model: $\chi^2(3762) = 7725.59$, $p = .00$; $\chi^2/df = 2.05$, CFI = .904, AGFI = = .857, RMSEA = .031 [95% CI .030–.032], SRMR = .042. Goodness-of-fit indices for the model with 18 lower-order factors and one higher-order factor are slightly lower: $\chi^2(3897) = 8650.12$, $p = .00$; $\chi^2/df = 2.22$, CFI = .885, AGFI = = .846, RMSEA = .042 [95% CI .042–.043], SRMR = .055. Lack of fit was found in the case of the one-factor model (except RMSEA and SRMR, whose values were acceptable): $\chi^2(3915) = 24604.20$, $p = .00$; $\chi^2/df = 6.29$, CFI = .499, AGFI = .613, RMSEA = .070 [95% CI .069–.071], SRMR = .078.

General fit indices for the 18-factor model in the independent sample (Study 2) yielded ambiguous results. The corrected χ^2 statistic had a value of 8753.21, $df = 3762$, $p = .00$, showing a lack of fit. At the same time, given the complexity of the model, χ^2 divided by the number of degrees of freedom showed acceptable fit ($\chi^2/df = 2.33$). The values of CFI (.880) and AGFI (.803) showed a lack of good fit of the model. The value of RMSEA (.038; 95% CI [.038-.039]) and SRMR (.045) indicate good fit. The model with 18 factors and one general higher-order factor corresponding to the overall scale had slightly weaker – though comparably interpreted – goodness-of-fit indices than the 18-factor model: $\chi^2(3897) = 9922.61$, $p = .00$; $\chi^2/df = 2.55$, CFI = .855, AGFI = .785, RMSEA = .041 95% CI [.041–.042], SRMR = .066. In the case of the one-factor model, the following measures indicated a lack of fit: corrected χ^2 (3915) = 25205.57, $p = .00$; $\chi^2/df = 6.44$, CFI = .487, AGFI = .522. RMSEA (.078; 95% CI [.077–.079]) and SRMR (.088) indicated a fit on the border of acceptability.

The results of the analysis of the local fit of the 18-factor model to the data from the independent sample (Study 2) are presented in Table 4. All factor loadings were above .50. The values of the *omega* coefficient exceeded .80, attesting to the good and very good reliability of the factors, except in the case of the factor corresponding to the *Entitlement/Grandiosity* scale (ω = .79). The average variance extracted exceeded the minimal target level of .50 for specific factors except *Vulnerability to Harm or Illness* (AVE = .48), confirming the good reliability of the measures of schemas. All factors except the one corresponding to the *Self-Sacrifice* schema were intercorrelated ($p < .01$) at levels ranging from weak ($r = .22$ for *Punitiveness* and *Emotional Deprivation*) to strong ($r = .76$ for *Defectiveness/Shame* and *Social Isolation/Alienation*).

Table 4
Results of Confirmatory Factor Analysis of the Young Schema Questionnaire: YSQ-ES-PL (Study 2 Sample)

Scale / item	Factor loadings (standardized)					Scale reliability (Cronbach's α coefficient)	Factor reliability (ω coefficient)	Average variance extracted
	1	2	3	4	5			
ED	.813	.872	.911	.864	.851	.94	.93	.74
AB	.818	.869	.853	.760	.797	.91	.91	.67
MA	.636	.834	.889	.840	.789	.89	90	.64
SI	.717	.877	.891	.899	.843	.93	.92	.71
DS	.833	.830	.845	.742	.823	.91	.91	.66
FA	.789	.834	.846	.842	.800	.91	.91	.68
DI	.796	.855	.864	.753	.572	.88	.88	.60
VU	.562	.666	.614	.809	.788	.82	.82	.48
EU	.683	.727	.790	.809	.725	.86	.86	.55
SB	.747	.606	.802	.793	.667	.86	.84	.52
SS	.782	.862	.771	.812	.692	.90	.89	.61
EI	.691	.744	.800	.767	.697	.86	.86	.54
US	.702	.841	.828	.828	.756	.90	.90	.63
ET	.622	.615	.757	.718	.587	.81	.79	.43
IS	.738	.845	.816	.766	.639	.88	.87	.58
AS	.622	.784	.785	.775	.718	.86	.85	.54
NP	.769	.851	.848	.806	.698	.90	.90	.63
PU	.742	.793	.829	.831	.804	.90	.90	.64

Note. YSQ scales: ED – *Emotional Deprivation*, AB – *Abandonment/Instability*, MA – *Mistrust/Abuse*, SI – *Social Isolation/Alienation*, DS – *Defectiveness/Shame*, FA – *Failure to Achieve*, DI – *Dependence/Incompetence*, VU – *Vulnerability to Harm or Illness*, EU – *Enmeshment/Undeveloped Self*, SB – *Subjugation*, SS – *Self-Sacrifice*, EI – *Emotional Inhibition*, US – *Unrelenting Standards/Hypercriticalness*, ET – *Entitlement/Grandiosity*, IS – *Insufficient Self-Control/Self-Discipline*, AS – *Approval-Seeking/Recognition-Seeking*, NP – *Negativity/Pessimism*, PU – *Punitiveness.*

DISCUSSION

Based on the results obtained in the presented research, it can be concluded that the procedure of shortening the full version of YSQ-L3 yielded a reliable and valid instrument measuring early maladaptive schemas for our research purposes in Polish cultural conditions. Just like its original version, YSQ-ES-PL consists of 90 items, five in each of the 18 scales corresponding to particular schemas according to Young's conception.

Principal component analysis, applied in the procedure of shortening the YSQ, has a rather descriptive character, but it can be used as a data reduction technique (Borsboom, 2005). According to some scholars, exploratory factor analysis is a more valid procedure for shortening psychometric instruments than PCA (cf. Costello & Osborne, 2005). Others believe that principal component analysis yields similar results (cf. Thompson, 2004) and that its application for this purpose is justified and practiced (Tabachnik & Fidell, 2013). Despite the above points of controversy, the method of shortening the instrument was consistent with the assumptions adopted when developing the English version of the YSQ (Schmidt et al., 1995; Young, 1998). Exploratory factor analysis was used as a preliminary method of testing the solution developed. PCA made it possible to identify the scales with relatively high internal consistency at the cost of the risk of narrowing down the contents of dimensions to a set of the most strongly intercorrelated items. Because in the presented research we decided to replicate the original procedure, the obtained instrument – just like its English-language version – is not free from this limitation. However, high correlations between both short versions and the long version show that all versions are comparable in terms of content. For YSQ-ES-PL, the correlations of scales with corresponding ones in the long version exceeded .85 (for 13 of them, Pearson's r was higher than .90). The score on the whole YSQ-ES-PL scale correlated with YSQ-L3 score at .99. It should be noted that the order of items adopted in YSQ-ES-PL was analogous to the full version (items arranged according to the order of the scales). We decided to adopt this solution in order to enable adequate comparison of the long and short versions, despite certain weak points of the solution, such as susceptibility to biases in answers (cf. Rijkeboer, 2012).

Reliability analysis revealed that – despite the shortening of the scales – high internal consistency was maintained both for the whole instrument and for the measures of specific dimensions. Except for the *Self-Sacrifice* schema (Cronbach's $\alpha = .79$), measurement reliability exceeded $\alpha = .80$ for all scales, suggesting the usefulness of the instrument both for research purposes and in individual

diagnosis. Internal consistency parameters turned out to be higher compared to those obtained in some other language versions, e.g., Canadian-French (Hawke & Provencher, 2012), German (Kriston et al., 2013), or Danish (Bach et al., 2017). This may be due to the replication of the procedure of instrument shortening, adopted in the Polish study instead of using the direct translation of the English short version, and to the order of items.

The positive correlations of the overall measure of schemas with beliefs characteristic for personality disorders are an additional indicator of the validity of YSQ-ES-PL. As expected, this correlation was the strongest for borderline personality disorder, which is consistent with the theoretical assumptions and with the results of the existing empirical studies (cf. Bach et al., 2017; Nordahl et al., 2005; Young et al., 2014). Correlations above .35 (Pearson's *r*) with all beliefs except those characteristic for schizoid and antisocial personality disorders probably reflect the broad scope of the contents of the 18-schema set. The characteristics of schizoid and antisocial personality disorders were not associated with the intensity of particular schemas (measured by means of the long version of YSQ-2) in the study by Nordahl and colleagues (2005), either. This may be understood as the specificity of these disorders, whose clinical picture is less clearly related to cognitive contents than it is to behavioral correlates. It is also possible that, in both studies, the participants with these characteristics – with their low levels, except in the specific clinical population – were significantly underrepresented. A study conducted on a Danish clinical sample of people with personality disorders yielded a negative association between antisocial personality disorder and the schemas distinguished by Young (Bach et al., 2017). This was interpreted as stemming from the specificity of the content of the schemas, narrower than the scope of cognitive contents characteristic for this disorder, as well as for others. The associations obtained in the present analyses are significantly stronger (in the positive direction) than in the Danish study. This is probably due to the fact that in the Polish sample most of the subjects belonged to the general population. Moreover, the applied instrument – the PBQ – is not a measure of personality pathology but only a measure of its cognitive correlates. The schemas according to Young may therefore be more strongly associated with beliefs according to Beck than with the level of the same disorder as defined in accordance with the diagnostic criteria. An analysis of the specificity of schemas for particular personality disorders or for the beliefs related to them goes beyond the scope of the present paper. However, it is worth stressing the marked associations between the characteristics of personality disorders and the schemas corresponding in terms of content to their clinical picture. The association of borderline

personality disorder with many schemas, particularly those involving the experience of disconnection, abandonment, or dependence, is consistent both with the assumptions of Young's theory and with earlier empirical studies (Arntz et al., 1999; Bach et al., 2017; Nordahl et al., 2005; Young et al., 2014). At the same time, systematic correlations of the levels of the schemas with all PBQ scales suggest that the YSQ may be understood as a measure of general predispositions for pathologies rather than as basis for the prediction of a particular diagnosis. This seems to be confirmed by the significantly higher intensity of the schemas (except *Self-Sacrifice*) in a diverse clinical sample compared to the general population, consistent with earlier studies investigating this issue (cf. Kriston et al., 2013; Rijkeboer et al., 2005). The lack of differences in *Self-Sacrifice* should be regarded as specific to this sample, to the cultural context, or to this version of the instrument. Moreover, the associations of schemas with cognitive correlates of personality disorders suggest that they may be treated as trait-like constructs, as was proposed by Young (2014).

Based on confirmatory factor analysis, it can be concluded that the model with 18 factors corresponding to specific schemas and the 18-factor model with a general factor corresponding to the overall scale seem to be better fitted to the data than the one-factor model. The tested models were better fitted to the data from Study 1, which is due to the fact that they were optimized in this particular sample. The verification performed on data from the independent sample supports the main findings concerning factorial validity, though it should be stressed that these findings are not unambiguous any more. While the corrected χ^2 statistic as well as CFI and AGFI indices show a lack of acceptable model fit, the values of χ^2/df, RMSEA, and SRMR attest to good fit to the data. Similar divergences were found in some of the earlier studies on the factorial structure of different language versions of the YSQ (cf. Kriston, Schäfer, von Wolff, Härter, & Hölzel, 2012). The statistical significance of χ^2 test seems to be related to the size of the sample and the complexity of the model. Also AGFI is an index susceptible to the underestimation of goodness of fit in cases of high model complexity, which may explain its insufficient value (Schermelleh-Engel et al., 2003). Analogous divergences were found in studies validating the German and Danish versions, in which good model fit was concluded based on more robust indices (RMSEA and SRMR) and adequately high factor loadings (Bach et al., 2017; Kriston et al., 2012). In the analyses presented in this article, χ^2 divided by the number of degrees of freedom, RMSEA, SRMR, as well as the values of factor loadings (exceeding .50, and in most cases exceeding .70), the reliability coefficients, and average variance extracted show that the proposed solution has

adequate factor validity. The 18-factor model legitimizes distinguishing of scales for particular schemas, and the model with the general factor additionally supports the use of the general scale in calculations. However, due to the unacceptable values of some indices and the fairly high intercorrelation of some of the factors, we suggest further analyses including the exploration of modification indices.

In our opinion, further studies should also be conducted on a larger and more precisely defined clinical sample; this refers in particular to patients diagnosed with personality disorders. The presented analyses do not allow for confirming the test-retest reliability of the obtained results, which is theoretically postulated and has been verified for some of the language versions of the instrument.

To sum up, the presented study made it possible to develop the psychometrically tested Polish version of the instrument measuring the intensity of early maladaptive schemas according to Young's model. The obtained results indicate that the short YSQ questionnaire that we have proposed may be useful both in scientific research and in individual diagnosis. This seems to be particularly important in the context of the fact that schema therapy has been systematically gaining the status of an evidence-based instrument with regard to the treatment of practically the entire spectrum of personality disorders.

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APPENDIX

BASIC SCHEMA THERAPY TERMS

The first column of the table contains original English terms; the remaining columns contain their Polish equivalents used in six publications issued in Poland.

Original version	**Polish equivalent**					
Young, Klosko, & Weishaar (2003)[1]	Beck, Freeman, & Davies (2005)[2]	**Popiel, & Pragłowska (2008)**[3]	Rafaeli, Bernstein, & Young (2011)[4]	**Young, Klosko, &Weishaar (2014)**[5]	Arntz & van Genderen (2016)[6]	**Staniaszek & Popiel (2017)**[7] *Proposed canonical version*
Schema Therapy (schema-focused approach)	Zorientowany na schematy model poznawczy	**Terapia zorientowana na schematy**	Terapia schematu (Psychoterapia skoncentrowana na schematach)	**Terapia schematów**	Terapia schematów (Terapia skoncentrowana na schematach)	**Terapia schematów**
Early Maladaptive Schemas	Wczesne schematy dezadaptacyjne	**Wczesne schematy dezadaptacyjne**	Wczesne schematy nieadaptacyjne	**Wczesne nieadaptacyjne schematy**	Schematy	**Wczesne schematy dezadaptacyjne**

[1] Young, J. E., Klosko, J. S., & Weishaar, M. (2003). *Schema therapy. A practicioner's guide*. New York: The Guilford Press.

[2] Beck, A. T., Freeman, A., & Davis, D. D. (2005). *Terapia poznawcza zaburzeń osobowości*. Kraków: Wydawnictwo UJ.

[3] Popiel, A., & Pragłowska, E. (2008). *Psychoterapia poznawczo-behawioralna. Teoria i praktyka*. Warszawa: Wydawnictwo Paradygmat.

[4] Rafaeli, E., Bernstein, D., & Young, J. (2011). *Psychoterapia skoncentrowana na schematach*. Warszawa: Instytut Psychologii Zdrowia.

[5] Young, J. E., Klosko, J. S., & Weishaar, M. (2014). *Terapia schematów*. *Przewodnik praktyka*. Sopot: Gdańskie Wydawnictwo Psychologiczne.

[6] Arntz, A., & van Genderen H. (2016). *Terapia schematów w zaburzeniu osobowości typu borderline*. Gdańsk: Gdańskie Wydawnictwo Psychologiczne.

[7] More detailed explanations of the Polish translations of English terms are available in the Appendix in the Polish version of this paper.

Abandonment / Instability	Porzucenie / brak stabilności	**Porzucenie / brak stabilności**	Porzucenie niestabilność więzi	**Opuszczenie / Niestabilność Więzi**	Opuszczenie / Niestabilność Więzi	**Opuszczenie / Niestabilność więzi**
Mistrust / Abuse	Nieufność / przemoc	**Nieufność**	Podejrzliwość / krzywdzenie	**Nieufność / Skrzywdzenie**	Nieufność / Skrzywdzenie	**Nieufność / Skrzywdzenie**
Emotional Deprivation	Deprywacja emocjonalna	**Deprywacja emocjonalna**	Deprywacja emocjonalna	**Deprywacja Emocjonalna**	Deprywacja Emocjonalna	**Deprywacja emocjonalna**
Defectiveness / Shame	Ułomność / wstyd	**Ułomność / wstyd**	Niepełnowartościowość / wstyd	**Wadliwość/ Wstyd**	Wadliwość/ Wstyd	**Wadliwość / Wstyd**
Social Isolation / Alienation	Społeczna izolacja / wyobcowanie	**Izolacja społeczna**	Izolacja społeczna / alienacja	**Izolacja Społeczna / Wyobcowanie**	Izolacja Społeczna / Wyobcowanie	**Izolacja społeczna**
Dependence / Incompetence	Zależność/ niekompetencja	**Zależność / brak kompetencji**	Zależność / niekompetencja	**Zależność / Niekompetencja**	Zależność/ Niekompetencja	**Zależność / Niekompetencja**
Vulnerability to Harm or Ilness	Narażenie na „przypadkowe” zdarzenia	**Kruchość, wrażliwość**	Podatność na zranienia i choroby	**Podatność na Zranienie lub Zachorowanie**	Podatność na Zranienie i Zachorowanie	**Poczucie zagrożenia**
Enmeshment / Undeveloped Self	Rozmycie granic / słabo rozwinięte poczucie siebie	**Rozmycie granic**	Uwikłanie / rezygnacja z Ja	**Uwikłanie Emocjonalne / Nie w Pełni Rozwinięte Ja**	*none*	**Uwikłanie emocjonalne / Brak poczucia własnej odrębności**
Failure to achieve	Porażka	**Porażka**	Skazanie na niepowodzenie	**Porażka**	Porażka	**Porażka**
Entitlement/ Grandiosity	Uprzywilejowanie dominacja	**Uprzywilejowanie / dominacja**	Roszczenia / wyolbrzymione Ja	**Roszczeniowość / Wielkościowość**	Roszczeniowość	**Uprzywilejowanie / Poczucie wyższości**

Insufficient Self-Control/ Self-discipline	Niewystarczająca samokontrola/ samodyscyplina	**Niewystarczająca samokontrola/ samodyscyplina**	Niedostateczna samokontrola i samodyscyplina	**Niedostateczna Samokontrola i Samodyscyplina**	Niewystarczająca Kontrola/ Samodyscyplina	**Niedostateczna samokontrola**
Subjugation	Podporządkowanie	**Podporządkowanie**	Podporządkowanie się	**Podporządkowanie się**	Podporządkowanie	**Podporządkowanie**
Self-Sacrifice	Poświęcenie siebie	**Samopoświęcenie**	Poświęcanie siebie	**Samopoświęcenie**	*none*	**Samopoświęcenie**
Approval-Seeking/ Recognition-Seeking	Szukanie aprobaty	**Poszukiwanie aprobaty/ uznania**	Poszukiwanie aprobaty/ uznania	**Poszukiwanie Akceptacji i Uznania**	*none*	**Poszukiwanie aprobaty i uznania**
Negativity/ Pessimism	Uwrażliwienie na zdarzenia, które „można kontrolować” /negatywizm	**Pesymizm**	Negatywizm/ pesymizm	**Negatywizm/ Pesymizm**	*none*	**Negatywizm/Pesymizm**
Emotional Inhibition	Nadmierna kontrola	**Zahamowanie emocjonalne**	Stłumienie uczuć	**Zahamowanie Emocjonalne**	Zahamowanie Emocjonalne	**Zahamowanie emocjonalne**
Unrelenting Standards/ Hypercriticalness	Bezlitosne normy	**Bezlitosne normy**	Bezwzględne standardy/ hiperkrytycyzm	**Nadmierne Wymagania/ Nadmierny Krytycyzm**	Nadmierna Wymagania/Nadmierny Krytycyzm	**Bezwzględne standardy/Nadmierny krytycyzm**
Punitiveness	Skłonność do wymierzania kar	**Skłonność do wymierzania kar**	Nastawienie na karanie	**Bezwzględna Surowość**	Bezwzględna Surowość	**Skłonność do karania**
Domain	Kategoria	**Domena**	Obszar	**Obszar schematów**	*none*	**Obszar**
Disconnection and Rejection	Oderwanie i odrzucenie	**Opuszczenie i odrzucenie**	Rozłączanie i odrzucanie	**Rozłączenie i odrzucenie**	*none*	**Brak więzi i odrzucenie**
Impaired Autonomy and Performance	Ograniczenie autonomii i możliwości działania	**Ograniczenie autonomii**	Uszkodzenie autonomii i sprawności	**Osłabiona autonomia i brak dokonań**	*none*	**Ograniczona autonomia i niskie umiejętności**

Impaired Limits	Zachwianie granic	**Zachwianie granic**	Uszkodzone granice	**Uszkodzone granice**	*none*	**Niedostateczne ograniczenia**
Other Directedness	Ukierunkowanie na inną osobę	**Ukierunkowanie na innego**	Skoncentrowanie się na innych ludziach	**Nakierowanie na innych**	*none*	**Ukierunkowanie na innych**
Overvigilance and Inhibition	Nadmierna czujność i zahamowanie	**Nadmierna czujność i zahamowanie**	Nadmierna podejrzliwość i zahamowania	**Nadmierna czujność i zahamowanie**	*none*	**Nadmierna czujność i zahamowanie**
						Not present in this text (proposed):
Schema mode	Aktywny styl schematów	**Aktywny styl schematów**	Tryb	**Tryb schematów**	Tryb schematów	***Tryb***
Child modes	Style dziecka	**Style dziecka**	Tryby dziecięce	**Tryby dziecięce**	Tryby dziecięce	***Tryby dziecięce***
Vulnerable Child	Uwrażliwione dziecko	**Wrażliwe dziecko**	Wrażliwe na krzywdzenie dziecko	**Wrażliwe Dziecko**	Skrzywdzone dziecko	***Bezbronne dziecko***
Angry Child	Rozzłoszczone dziecko	**Rozgniewane dziecko**	Rozzłoszczone dziecko	**Złoszczące się Dziecko**	Złoszczące się/ impulsywne dziecko	***Złoszczące się dziecko***
Impulsive/ Undisciplined Child	Impulsywne/niezdyscyplinowane dziecko	**Niegrzeczne dziecko**	Impulsywne dziecko	**Impulsywne i Niezdyscyplinowane Dziecko**	*none*	***Impulsywne/ Niezdyscyplinowane Dziecko***
Happy Child	Zadowolone dziecko	**Zadowolone dziecko**	Zadowolone dziecko	**Szczęśliwe Dziecko**	*none*	***Zadowolone dziecko***
Dysfunctional Coping modes	Style nie przystosowawczego radzenia sobie	**Style nie przystosowawczego radzenia sobie**	Nieadaptacyjne tryby radzenia sobie	**Nieadaptacyjne tryby radzenia sobie**	*none*	***Dysfunkcyjne tryby radzenia sobie***
Compliant Surrenderer	Uległa rezygnacja	**Uległy poddany**	Uległy poddany	**Uległy Poddany**	*none*	***Uległy poddany***
Detached Protector	Brak obrońcy	**Brak obrońcy**	Odłączony opiekun	**Odłączony Obrońca**	Odłączony obrońca	***Odłączony obrońca***

Overcompensator	Nadmierna kompensacja	**Superkompensator**	Nadkompensator	**Nadmierny Kompensator**	*none*	***Nadkompensator***
Dysfunctional parent modes	Style dysfunkcjonalnego rodzica	**Style dysfunkcjonalnego rodzica**	Dysfunkcjonalne tryby uwewnętrznionego rodzica	**Nieadaptacyjne tryby rodzicielskie**	*none*	***Dysfunkcyjne tryby rodzicielskie***
Punitive/ Critical Parent	Karzący rodzic	**Karzący rodzic**	Karzący rodzic	**Karzący Rodzic**	Karzący rodzic	***Karzący rodzic***
Demanding Parent	Wymagający rodzic	**Wymagający rodzic**	Wymagający rodzic	**Wymagający Rodzic**	*none*	***Wymagający rodzic***
Healthy Adult mode	Zdrowy dorosły	**Zdrowy dorosły**	Zdrowy dorosły	**Zdrowy Dorosły**	Zdrowy dorosły	***Zdrowy dorosły***