

Healthy Schema Modes Mediate the Relationship between Emotional Childhood Trauma and Quality of Life in Patients with Personality Disorders

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Abstract

Introduction. Emotional childhood trauma has consistently been associated with impaired quality of life in individuals with personality disorders, yet the mechanisms underlying this relationship remain insufficiently understood. Schema therapy suggests that schema modes, reflecting momentary emotional–cognitive–behavioural states, may play a key role in explaining how early emotional adversity impacts later functioning. **Methods.** In a cross-sectional design, self-report data were collected from 147 adults diagnosed with a personality disorder. To examine whether schema modes mediate the relationship between emotional childhood trauma and quality of life, two mediation models were tested. One model included maladaptive modes (child, parent, and coping modes) as parallel mediators, whereas a second model examined healthy schema modes as a single mediator. For both models, emotional childhood trauma and quality of life were the predictor and outcome variable, respectively. **Results.** Results indicated that maladaptive schema modes did not significantly mediate the relationship between emotional childhood trauma and quality of life. In contrast, healthy modes significantly mediated this relationship, such that higher levels of emotional childhood trauma were associated with lower healthy mode functioning, which in turn predicted lower quality of life. **Conclusions.** These findings suggest that reduced adaptive functioning, rather than the presence of maladaptive schema modes, may be a central mechanism linking emotional childhood trauma to diminished quality of life. Clinically, the results highlight the importance of strengthening healthy schema modes in schema therapy to promote meaningful improvements in mental well-being beyond symptom reduction.

Healthy Schema Modes Mediate the Relationship between Emotional Childhood Trauma and Quality of Life in Patients with Personality Disorders

Quality of life (QoL) is a multidimensional construct, which has gained increasing attention and has been found to be an accurate reflection of one's wellbeing (Sanderson & Andrews, 2002). QoL relates to an individual's perception of their own position in life in the context of their culture and value systems, and in relation to their own goals, expectations, standards, and concern (WHO, 1994). Rather than focusing solely on symptom reduction, the assessment of QoL offers a broader understanding in therapeutic outcomes and subjective wellbeing (Chakhssi et al., 2021; Ruggeri et al., 2001; Soeteman et al., 2008).

Whereas physical illness evidently impacts people's QoL, mental health issues seem to have similar effects (Soeteman et al., 2008). A substantial body of research has demonstrated that the presence of a PD is associated with markedly reduced quality of life (Cramer et al., 2006; Ruggeri et al., 2001; Skodol et al., 2002; Soeteman et al., 2008; Trompenaars et al., 2024), comparable to those of patients with severe somatic conditions, such as Parkinson's disease or lung cancer (Soeteman et al., 2008). This impairment is particularly evident in domains such as interpersonal functioning, identity, and emotion regulation, which are central features of personality pathology (DSM-5-TR; American Psychiatric Association, 2022).

In the general adult population, a prevalence of 13% has been found for personality disorders (Zimmerman et al., 2008), and up to 64% in the clinical population, according to Kongerslev et al. (2015). Research indicates that various PDs differ in how severely they impact QoL, challenging the predominant clinical focus on borderline PD (Soeteman et al., 2008).

Borderline PD is often associated with impairments in social and occupational functioning, a poor sense of self and self-image, which negatively impacts self-reported QoL (Cramer et al., 2006). In contrast to expectations, dependent, paranoid, and narcissistic PD classifications were associated with a more severe burden than borderline PD. This indicates that the impact of PDs beside borderline PD on QoL should not be underestimated. Other studies identified that schizotypal PD, avoidant PD, paranoid PD, and borderline PD were most strongly related to a reduced QoL (Cramer et al., 2006; Skodol et al., 2002).

Temperamental, cognitive, and genetic differences between individuals may partly explain the contrasting research findings (Narud & Dahl, 2002). Altogether, personality – consisting of coping styles and abilities to overcome and adapt factors – determines our

interpretation of events, and personality traits are important for the perception of QoL (Narud & Dahl, 2002).

The association between PD and reduced QoL may be illustrated based on the theoretical framework of schema therapy (Young, 1990). According to Young (1990), people who experience childhood trauma often develop pervasive dysfunctional patterns, which he called schemata. These consist of a combination of thoughts, emotions, and attention tendencies that influence one's behaviour, worldview, and identity. More broadly, he conceptualized schema modes as a cognitive-emotional state including a coping response, related to specific schemata (Young, 1990). These schema modes are divided into four categories: (1) Child modes; (2) Dysfunctional Parent modes; (3) Maladaptive Coping modes; and (4) Healthy modes, where child modes, parent modes and coping modes are considered maladaptive modes (Lobbestael et al., 2005). For example, the Critical Parent mode includes shame and self-disgust considered as internalized childhood experiences of criticism or punishment (Bach & Bernstein, 2019). Intensity of schema modes seems to correlate with severity of PD (Dadashzadeh et al., 2016) and improvement in schema modes is associated with improvement in QoL (Mahmoodinejad et al., 2025).

A central goal of schema therapy is to assess and empower the healthy modes, namely the Healthy Adult mode and the Happy Child mode, so that it may take care of the basic emotional needs experienced by the vulnerable part of the self (Jacob & Arntz, 2013; Martin & Young, 2010; Young et al., 2003). In the Healthy Adult mode, people can cope with emotions, solve problems and create healthy relationships while being aware of their needs, possibilities and limitations (Young et al., 2003). According to several studies, the Healthy Adult might be seen as a transdiagnostic mode, reflecting healthy functioning (Bach & Anderson, 2020; Bach & Bernstein, 2019; Yakin et al., 2026). The Happy Child mode involves joy, play, and spontaneous behaviour (Young et al., 2003).

Yakin and Arntz (2023) performed an analysis of both healthy modes, and results indicated that the Healthy Adult mode seems to have a reciprocal relationship with the Happy Child mode. The Healthy Adult mode strengthens the Happy Child mode, and Happy Child mode boosts the Healthy Adult with spontaneity and happiness, which both seemed to be correlated with emotional stability and resilience (Yakin & Arntz, 2023).

Previously, Mertens and colleagues (2020) demonstrated a mediating role of schema modes in the relationship between emotional abuse in childhood and differential manifestations of PDs (Mertens et al., 2020). Their findings indicated that the impact of emotional abuse on PDs is significantly mediated by all mode clusters, which implies that PDs are not directly

caused by emotional abuse, but rather by how individuals have learned to cope with the emotional abuse (Mertens et al., 2020). Currently, it has not yet been investigated whether schema modes (healthy modes and maladaptive modes), reflecting both behavioural patterns and emotional states, can be viewed as a transdiagnostic mediating factor explaining the relationship between childhood emotional trauma and quality of life.

Research has identified childhood traumatic events, specifically childhood maltreatment, as a major predictor for the development of PD (Ingenhoven, 2015 & Skodol et al., 2005). This goes for all types of childhood maltreatment, including sexual, physical or emotional abuse, or emotional and/or physical neglect (Lobbestael et al., 2010). However, research points out that emotional abuse seems to stand out in terms of negative impact in later life (Lobbestael et al., 2010). Emotional abuse has been found to independently and significantly predict paranoid, schizoid, borderline, avoidant, dependent, and obsessive-compulsive PD (Lobbestael et al., 2010).

Emotional neglect may predict dysfunctional attachment styles and poor self-esteem (Liu et al., 2018), concepts which are represented in the schema modes. Emotional neglect is currently understudied and therefore even more relevant in this study (Liu et al., 2018). At a time when mental health services are overburdened due to high demand, and a shift toward recovery-oriented care is ongoing, understanding the role of schema modes in the impact of emotional childhood trauma becomes essential. Schema modes may offer a clinical framework to more efficiently target core psychological issues and enhance quality of life. Treating personality disorders typically involves complex and prolonged therapeutic interventions. By investigating how schema modes mediate the relationship between emotional trauma and quality of life, this study contributes to more targeted and effective clinical interventions.

This study investigates whether the relationship between emotional childhood trauma and quality of life is mediated by schema modes in individuals with a personality disorder. It was hypothesized that schema modes would mediate this relationship in two distinct ways. First, maladaptive schema modes (including dysfunctional child modes, coping modes, and parent modes) were expected to function as parallel mediators, such that higher levels of emotional childhood trauma would be associated with higher levels of maladaptive schema modes, which in turn would be associated with lower quality of life. Second, healthy schema modes, the Healthy Adult and Happy Child mode, were expected to mediate the association between emotional childhood trauma and quality of life, such that higher levels of emotional childhood trauma would be associated with lower levels of healthy modes, which in turn would be associated with lower quality of life.

Method

Participants

A mediation-analysis was carried out using baseline data from the Dutch study Time-limited Experiential versus long-term schema therapy: Non-inferiority trial for Groups of Outpatients with personality disorders (TEN-GO!), as approved by the Medical Research Ethics Committee (MEC-2024-0227). These patients were recruited from Parnassia Groep, G-Kracht Psychomedisch Centrum, GGZ Delfland, Eleos, Max Ernst GGZ, and GGZ Centraal. To participate, a participant had to be at least 18 years old, meet the DSM-5 classification of a personality disorder, and had to be eligible for group therapy based on symptoms of personality disorders being the reason for seeking help, motivation to follow psychotherapy in a group and the clinical judgement of the group therapists. Before participation, all subjects read and signed an informed consent form.

A sample size of 148 was used in this study. This sample size was needed to detect an effect size of $f^2 = .15$ with $\alpha = .05$, two-tailed with a power of .90. This has been calculated with G*Power (Faul et al., 2009). Participants were on average 35.6 years old ($SD = 10.8$), with ages ranging from 19 to 65. Participants were mostly female ($n = 103$; 69.59%), whereas 45 participants were male ($n = 30.41\%$). Most participants had a Dutch nationality ($n = 114$; 77.03%), whereas 34 participants ($n = 23.06\%$) had a different nationality.

Table 1 shows the frequency of personality disorders in this sample and participants' highest educational level. Of 148 participants, 21 participants ($n = 14.19\%$) were diagnosed with more than one personality disorder. Sixty-five participants ($n = 43.29\%$) were receiving psychological treatment at the time of the baseline assessment and, and 127 participants ($n = 85.82\%$) had ever received psychological treatment in the past. For a full overview of Demographic Characteristics, see Appendix A.

Table 1*Demographic Characteristics of Participants at Baseline (N= 148)*

Demographic variables	<i>n</i>	<i>%</i>
Highest educational level		
ISCED 1: Primary Education	1	0.68
ISCED 2: Lower Secondary Education	19	12.84
ISCED 3: Upper Secondary Education	60	40.54
ISCED 4: Post-secondary Non-tertiary Education	13	8.78
ISCED 6: Bachelor's or Equivalent Level	35	23.65
ISCED 7: Master's or Equivalent Level	20	13.51
Personality Disorder Diagnosis		
Obsessive-compulsive PD	30	20.27
Dependent PD	7	4.73
Avoidant PD	61	41.22
Borderline PD	30	20.27
Antisocial PD	1	0.68
Schizotypal PD	2	1.35
Paranoid PD	3	2.03
Other Specified PD	33	22.30

Note: Other demographic information is displayed in Appendix A.

Questionnaires and procedure

The current study employs a cross-sectional design, as part of the above-mentioned RCT. Participants had to fill in multiple questionnaires on a longitudinal period, though the current study only used baseline data of the following questionnaires.

Childhood Trauma Questionnaire-Short Form (CTQ-SF; Bernstein & Fink, 1998)

The CTQ-SF is a self-report surveys consisting of 28 items that assesses the experiences with five forms of childhood trauma: emotional abuse, emotional neglect, physical abuse, physical neglect, and sexual abuse. This study only uses the subscales of emotional abuse and emotional neglect, as predictive factors for developing schema modes and perceived quality of life. In the RCT, a Dutch translation of the CTQ was used, namely the Jeugd Trauma Vragenlijst (JTV; Thombs et al., 2009). An example is “When I was growing up, there was someone in my

family who helped me feel that I was important or special”, with the answer options “never true” “rarely true”, “sometimes true” “often true” and “very often true”. The questionnaire has shown good validity and reliability ($\alpha = .95$ for Emotional Abuse and $\alpha = .91$ for Emotional neglect), as reviewed in the Netherlands (Thombs et al., 2009) and confirmed in this study, see Table 2.

Schema Mode Inventory (SMI; Young et al., 2007)

The SMI is a 118-item self-report questionnaire covering 14 modes falling within four domains. In this study, all four domain scores will be used. Participants must select the option which is most applicable to themselves. An example is, translated from Dutch to English, “I feel loved and accepted”, with six answer options, from 1 (“never or almost never”) to 6 (“always”). The psychometric values are adequate, with a good internal consistency, see Table 2, and an adequate test-retest reliability and a moderate construct validity (Lobbestael et al., 2010). The psychometric values are adequate, with a good internal consistency of Cronbach’s alpha of .79 to .96, an adequate test-retest reliability and a moderate construct validity (Lobbestael et al., 2010), also confirmed in this study, see Table 2.

Mental Health Quality of Life (MH QoL; van Krugten et al., 2021)

The MH QoL questionnaire measures quality of life covering multiple aspects, specifically developed for use in people with mental health problems. The questionnaire is a self-report survey consisting of seven items, where participants must rate the degree of their satisfaction in aspects of mental health, covering relationships, self-image, independence, mood, daily activities, physical health and future. Items are rated on a four-point Likert scale, for example “self-image” as a topic with four answer options from 1 (“I think very positively about myself”) to 4 (“I think very negatively about myself”). The eighth and last item assesses the general wellbeing using a visual analogue scale from 0 to 100, where 0 is least imaginable mental wellbeing and 100 is best imaginable mental wellbeing. The MH QoL has a high internal consistency and test-retest reliability ($\alpha = .85$) and supported convergent validity (van Krugten et al., 2021). Cronbach's alpha of item 1-7 is presented in Table 2. The analyses in this study included item 8 only.

Analyses

A mediation-analysis was carried out using baseline data scores of the CTQ-SF (only emotional neglect and emotional abuse items), SMI and item 8 on MH QoL were measured to assess childhood trauma, schema modes and perceived quality of life of participants.

To investigate whether schema modes mediate the relationship between emotional childhood trauma and quality of life, two mediation models were specified and analysed in RStudio, according to PROCESS Model 4 (Hayes et al., 2018). The first model assessed the indirect effects of emotional childhood trauma on quality of life through three maladaptive schema modes (child modes, dysfunctional parent modes, and coping modes), which were included as parallel mediators. The second model examined the indirect effect through the healthy schema mode, which was entered as a single mediator variable. In both models, emotional childhood trauma was entered as the predictor, and quality of life was entered as outcome. Indirect effects were estimated using non-parametric bootstrapping with 5,000 resamples, as recommended for mediation analysis due to the non-normal sampling distribution of indirect effects (Hayes et al., 2018). Before estimating the models, assumptions relevant to mediation analysis were evaluated, including linearity, multivariate normality, absence of multicollinearity among mediators, and the independence of residuals. No violations of these assumptions were found.

Results

Descriptives

Descriptive statistics, such as *M*, *SD*, Cronbach's alphas, and the minimum and maximum scores are displayed in Table 2. Although emotional abuse and emotional neglect were conceptually combined into a single emotional childhood trauma score for the mediation analyses, descriptive statistics and reliability estimates are reported separately for each subdomain. One participant was excluded due to missing values, leaving *N* = 147. Table 3 shows all Pearson correlations between the variables. Emotional childhood trauma is positively correlated with child modes ($r = .29, p < .01$) and negatively with healthy modes ($r = -.25, p < .01$). Also, healthy modes were positively correlated with QoL ($r = .31, p < .001$).

Table 2*Descriptive Statistics*

Variables	<i>M</i>	<i>SD</i>	α	Min.	Max.
Emotional abuse	2.54	1.07	0.86	5	25
Emotional neglect	2.97	0.91	0.85	5	25
Child mode	2.62	0.62	0.93	1.37	4.41
Parent mode	3.26	0.82	0.88	1.40	5.33
Coping mode	2.60	0.55	0.90	1.53	4.03
Healthy mode	3.31	0.65	0.88	1.85	5.25
Quality of Life	47.27	18.26	0.74	0	80

Note: Cronbach's alpha was assessed for the QoL-items 1–7 only; the global QoL-rating (Item 8) is a single-item measure and was analysed separately.

Table 3*Correlations Between Variables*

Variables	1	2	3	4	5	6
1. Emotional childhood trauma	1.00					
2. Child modes	0.29*	1.00				
3. Parent modes	0.13	0.53***	1.00			
4. Coping modes	0.08	0.68***	0.53***	1.00		
5. Healthy modes	-0.25*	-0.45***	-0.33**	-0.40***	1.00	
6. Quality of Life	-0.10	-0.14	-0.22*	-0.07	0.31***	1.00

*Note: * $p < .05$, ** $p < .01$, *** $p < .001$. Emotional trauma consists of both emotional abuse and emotional neglect, as measured by Jeugd Trauma Vragenlijst (Thombs et al., 2009).*

Mediation analyses***Model 1: Maladaptive schema modes***

To investigate whether maladaptive schema modes mediated the relationship between childhood emotional trauma and quality of life, a parallel mediation analysis was performed including child modes, coping modes, and parent modes as mediators. The overall model predicting QoL was not statistically significant, $F(4, 142) = 2.30$, $p = .061$, $R^2 = .06$.

Emotional childhood trauma significantly predicted child modes, $B (SE) = 0.20 (0.05)$, $p < .001$, but not coping modes, $B (SE) = 0.05 (0.05)$, $p = .344$, or parent modes, $B (SE) = 0.11$

(0.07), $p = .128$. When controlling for emotional childhood trauma and the other schema modes, parent modes significantly predicted QoL, $B (SE) = -4.86 (2.18)$, $p = .027$, whereas child modes and coping modes did not.

The effect of emotional childhood trauma on QoL was not significant, $B (SE) = -2.36 (1.35)$, $p = .084$. The direct effect of emotional childhood trauma on QoL, controlling for all three maladaptive schema modes, was also not significant, $B (SE) = -1.53 (1.69)$, $p = .366$. None of the specific indirect effects via child modes ($ab = -0.44$, 95% $CI [-2.45, 1.30]$), coping modes ($ab = 0.16$, 95% $CI [-0.37, 0.99]$), or parent modes ($ab = -0.55$, 95% $CI [-1.75, 0.28]$) were statistically significant. The overall indirect effect was not significant. For an overview of the tested pathways, see Figure 1.

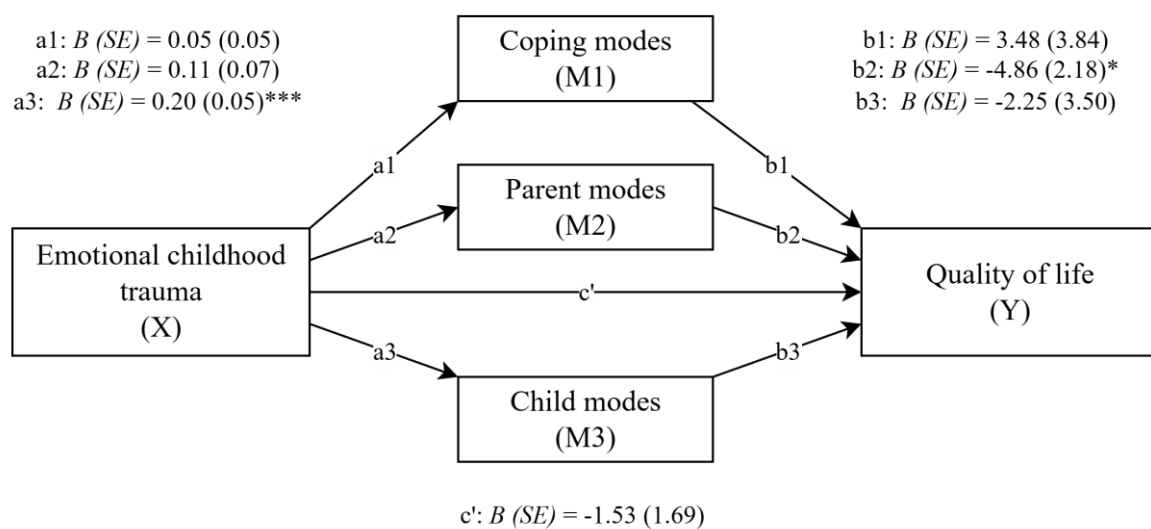


Figure 1. Model 1 summary. Note: * $p < .05$, ** $p < .01$, *** $p < .001$.

Model 2: Adaptive schema modes

The overall mediation model including emotional childhood trauma as predictor and healthy modes as mediator was significant, $F(2, 144) = 7.74$, $p = .001$, $R^2 = .10$. Higher levels of emotional childhood trauma significantly predicted lower levels of healthy modes, $B (SE) = -0.18 (0.06)$, $p = .002$. In turn, higher healthy modes scores significantly predicted higher QoL, controlling for emotional childhood trauma, $B (SE) = 8.23 (2.27)$, $p < .001$.

The total effect of emotional childhood trauma on QoL (not accounting for healthy modes) was not statistically significant, $B (SE) = -2.36 (1.35)$, $p = .084$. Likewise, the direct effect of emotional childhood trauma on QoL, controlling for healthy modes, was not significant, $B (SE) = -0.88 (1.61)$, $p = .584$. However, the indirect effect of emotional childhood

trauma on QoL through healthy modes was significant, $ab = -1.47$, 95% CI $[-2.92, -0.34]$, indicating an indirect-only mediation. For an overview of the tested pathways, see Figure 2.

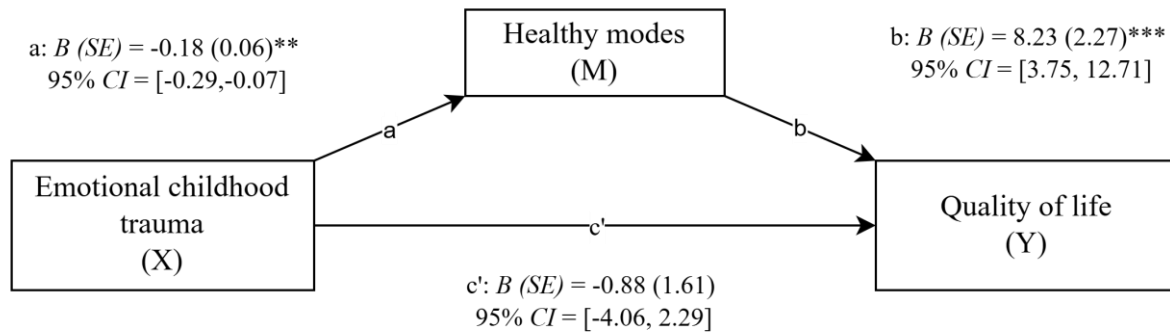


Figure 2. Model 2 summary. Note: * $p < .05$, ** $p < .01$, *** $p < .001$.

Discussion

The present study investigated whether schema modes mediate the relationship between emotional childhood trauma and quality of life in individuals with a personality disorder. Self-reported measures of emotional abuse, emotional neglect, schema modes and quality of life were analysed within two mediation models: one including maladaptive schema modes (child modes, coping modes, and parent modes) as parallel mediators, and one including healthy modes as a single mediator.

Results showed that, contrary to expectations (Narud & Dahl, 2002; Lobbetael et al., 2005; Mahmoodinejad et al., 2025; Mertens et al., 2020), child modes, coping modes, and parent modes did not significantly mediate the relationship between emotional childhood trauma and QoL. Although emotional childhood trauma was positively associated with child modes and several maladaptive modes were negatively associated with quality of life at correlational level, none of the indirect effects were statistically significant in the parallel mediation model. Seeing that parent modes emerged as a significant predictor of quality of life in the parallel mediation model suggests that critical or punitive internalized parent modes may directly undermine quality of life, independent of emotional childhood trauma (Bach & Bernstein, 2019). Parent modes may therefore represent a proximal factor influencing mental well-being rather than a mechanism through which childhood trauma affects quality of life.

In contrast to the maladaptive schema modes, healthy modes significantly mediated the relationship between emotional childhood trauma and QoL. Higher levels of emotional

childhood trauma were associated with lower scores of healthy modes, which in turn predicted lower QoL. Importantly, the direct effect of emotional childhood trauma on quality of life was no longer significant when healthy modes were included in the model, indicating that the association between emotional childhood trauma and quality of life may be fully accounted for by healthy modes. Despite the statistically significant mediation, it should be noted that in this model the explained variance was relatively low.

From a schema therapy perspective (Young, 1990), this finding is theoretically meaningful. The healthy modes encompass adaptive capacities such as emotion regulation, self-reflection, self-compassion, and effective coping (Fassbinder et al., 2014; Young et al., 2003). Emotional childhood trauma may interfere with the development of these capacities, resulting in reduced adaptive functioning in adulthood (Fassbinder et al., 2014). Rather than exerting a direct negative effect on QoL, emotional childhood trauma may affect quality of life indirectly by limiting healthy modes.

These findings suggest that the absence of adaptive modes may be more critical for quality of life than the presence of maladaptive modes. This distinction indicates that healthy modes may represent a mechanism through which adverse emotional childhood events are associated with reduced mental well-being later in life, in line with previous research (Mertens et al., 2020, Thornton et al., 2025; Yakin & Arntz, 2023).

The present findings provide important clinical insights for schema therapy. While reducing maladaptive schema modes remains a core therapeutic goal, the results suggest that strengthening the healthy mode may add significant value to improving quality of life in individuals with a history of emotional childhood trauma. Interventions aimed at enhancing emotional regulation, adaptive coping strategies, and stimulating joy, spontaneity, and play may help patients meeting criteria for a personality disorder improve quality of life through resilience and emotional stability (Yakin & Arntz, 2023). Additional explicit focus on healthy mode development may therefore contribute to more sustainable improvements in quality of life beyond symptom relief alone. Nevertheless, the finding that parent modes significantly predict quality of life, independent of emotional childhood trauma, suggests that targeting punitive and demanding parent modes may be clinically relevant in schema therapy as well.

Several limitations should be considered when interpreting the results. First, the variables were assessed using self-reported measures, which may have resulted in response bias, as participants' answers could have been influenced by social desirability, limited self-awareness, or current emotional states. More definitive findings would have been obtained if this study had also included structured clinical interviews or clinician ratings. Second, the cross-

sectional design precludes causal conclusions. Additionally, it should be noted that the explained variance of the model including healthy modes was relatively low, indicating that although healthy modes constitute a significant mediating mechanism, a substantial proportion of variance in quality of life remains unexplained. Furthermore, longitudinal studies are needed to examine whether changes in healthy schema modes precede changes in QoL over time. Also, QoL was assessed using a single-item global rating, which may be less sensitive to specific domains of functioning. Future research may benefit from using multidimensional quality of life measures. As a final point, future studies may also benefit from differentiating between specific healthy schema modes, the Healthy Adult mode and the Happy Child mode, to examine whether they differentially contribute to quality of life.

In conclusion, the present study suggests that emotional childhood trauma is related to quality of life primarily through reduced healthy mode functioning rather than through maladaptive schema modes. These findings emphasize the central role of adaptive capacities in understanding the long-term impact of emotional trauma and support a therapeutic focus on strengthening healthy schema modes to enhance quality of life.

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Appendix

Extended sample characteristics (see Table 1)

Table 1

Demographic Characteristics of Participants at Baseline

Baseline characteristic	<i>n</i>	%
Gender		
Female	103	69.6
Male	45	35.6
Site		
Eleos	19	12.84
G-Kracht	15	10.14
GGZ Centraal	5	3.38
GGZ Delfland Spijkenisse	16	10.81
PSYQ Den Haag Lijnbaan	41	27.70
PSYQ Purmerend/Zaandam	16	10.81
PSYQ Rijnmond	18	12.16
PSYQ Utrecht	18	12.16
Highest educational level		
ISCED 0: Early Childhood Education	0	0
ISCED 1: Primary Education	1	0.68
ISCED 2: Lower Secondary Education	19	12.84
ISCED 3: Upper Secondary Education	60	40.54
ISCED 4: Post-secondary Non-tertiary Education	13	8.78
ISCED 5: Short-cycle Tertiary Education	0	0
ISCED 6: Bachelor's or Equivalent Level	35	23.65
ISCED 7: Master's or Equivalent Level	20	13.51
ISCED 8: Doctoral or Equivalent Level	0	0
Personality disorder diagnosis		
Obsessive-compulsive PD	30	20.27
Dependent PD	7	4.73
Avoidant PD	61	41.22
Borderline PD	30	20.27
Histrionic PD	0	0
Narcissistic PD	0	0
Antisocial PD	1	0.68
Schizotypal PD	2	1.35
Schizoid PD	0	0
Paranoid PD	3	2.03
Other Specified PD	35	23.65

Table 1*Demographic Characteristics of Participants at Baseline*

Baseline characteristic	<i>n</i>	%
Comorbid diagnosis		
AD(H)D	30	20.27
Depression (and dysthymia)	28	18.92
Personality disorder	21	14.19
Posttraumatic stress disorder	11	7.43
General Anxiety Disorder	8	5.41
Panic disorder	5	3.38
Social Anxiety Disorder	3	2.03
Other specified mood disorder	2	1.35
Other specified trauma or stressrelated disorder	2	1.35
Agoraphobia	1	0.68
Alcohol use disorder	1	0.68
Autism spectrum disorder	1	0.68
Bipolar disorder	1	0.68
Cannabis use disorder	1	0.68
Gambling disorder	1	0.68
Gender dysforia	1	0.68
Obsessive compulsive disorder	1	0.68
Other specified anxiety disorder	1	0.68
Other specified feeding or eating disorder	1	0.68
Sexual dysfunction disorder	1	0.68
Psychological treatment		
Currently receiving psychological treatment	65	43.9
Received psychological treatment in the past	127	85.8

Table 1*Demographic Characteristics of Participants at Baseline*

Baseline characteristic	<i>n</i>	%
Ethnic background		
Dutch	114	77.03
Surinamese	8	5.41
Antillean	5	3.38
Hungarian	3	2.03
Indian	2	1.35
Indonesian	2	1.35
Polish	2	1.35
Turkish	2	1.35
British	1	0.68
Chinese	1	0.68
Congolese	1	0.68
Colombian	1	0.68
Dominican	1	0.68
British	1	0.68
Eritrean	1	0.68
Italian	1	0.68
Pakistan	1	0.68
Somali	1	0.68
Sri Lankans	1	0.68
Sudanese	1	0.68

Note: N= 148.