SCHEMA THERAPY FOR BORDERLINE PERSONALITY DISORDER

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OUTLINE

Borderline Personality Disorder (BPD)
Beliefs about Self
Why Schema Therapy?
Schema Therapy components and process
Questions / Comments / Sharing

Acknowledgement and praise for role of BPD supporter
Message to you:
Listen and engage intently, although I don't really care whether you listen or not
I am excited and happy, although annoyed and certainly rather be elsewhere
You are the only audience that really seems to understand, although you just don't seem to get it
I love you and hate you

BPD – DIAGNOSTIC CRITERIA / SYMPTOMS

1.Frantic efforts to avoid real or imagined abandonment
2. A pattern of unstable and intense interpersonal relationships
3. Identity disturbance: marked & persistent unstable self-image or sense of self
4. Impulsivity in at least two areas potentially self-damaging
5. Recurrent suicidal behaviour, gestures, threats, or self-harm
6. Affective instability due to a marked reactivity of mood
7. Chronic feelings of emptiness
8. Inappropriate, intense anger or difficulty controlling anger
9. Transient, stress-related paranoid ideation or severe dissociative symptoms

TREATMENT COMPARISONS

DBT and other forms of CBT (e.g., anxiety/mood management)
- safety, distress tolerance
- mindfulness, emotional regulation, affective stability
- interpersonal skills

Less direct targeting of…
Identity disturbance (maladaptive sense of self)
- direct link with personality, 'Who I am'; long-term, pervasive
- 'what is left after the chaos is reduced or better managed?'
- prone to drop-out & relapse; on-going, periodic crises;
-'chameleon effect'

DBT considered best speciliased treatment modality; essentially standard cognitive-behavioral techniques for emotion regulation and reality-testing with concepts of distress tolerance, acceptance, and mindful awareness largely derived from contemplative meditative practice.

Dialectical behavior therapy (DBT). ...
Schema-focused therapy. ...
Mentalization-based therapy (MBT). ...
Systems training for emotional predictability and problem-solving (STEPPS). ...
Transference-focused psychotherapy (TFP). ...
Good psychiatric management.

WHY SCHEMA THERAPY FOR PD?

Often need to adapt general CBT approach as…

- Cognitions and behaviours are more rigid with PD clients
- Many PD clients will not follow traditional CBT techniques (especially 'homework')
- High 'drop-out' rates
- Intimate interpersonal problems are more central to problems of PD clients
- Need more directed at broader conceptions of self
- Gap between cognitive & emotional change is much greater with individuals with PD

*"I intellectually get it but I don't **feel** it"*

SCHEMA THERAPY

Developed by Jeffrey Young for use in treatment of personality disorders and other chronic disorders, such as when patients fail to respond or relapse after having been through other therapies (e.g., traditional CBT).

An integrative psychotherapy combining theory and techniques from CBT, psychoanalytic object relations theory, attachment theory, and Gestalt therapy.

Object relations theory in psychoanalytic psychology is the process of developing a psyche in relation to others in the childhood environment. It designates theories or aspects of theories that are concerned with the exploration of relationships between real and external people as well as internal images and the relations found in them.[1] It maintains that the infant's relationship with the mother primarily determines the formation of his personality in adult life.[2] Particularly, the need for attachment is the bedrock of the development of the self or the psychic organization that creates the sense of identity.[2]

Modern Attachment Theory is based in three principles which include bonding as an intrinsic human need; regulation of emotion and fear to enhance vitality; and promoting adaptiveness and growth

Gestalt therapy is an existential/experiential form of psychotherapy which emphasizes personal responsibility, and focuses upon the individual's experience in the present moment, the therapist–client relationship, the environmental and social contexts of a person's life, and the self-regulating adjustments people make as a result of their overall situation

SCHEMA THERAPY

Greater emphasis on the therapeutic relationship

More emphasis on affect (imagery, role-playing)

More discussion of childhood origins and developmental processes.

More active confrontation of cognitions

EARLY MALADAPTIVE SCHEMA

Disconnection/Rejection includes 5 schemas:

Abandonment/Instability

Mistrust/Expect Abuse

Emotional Deprivation

Defectiveness/Shame

Social Isolation/Alienation

Impaired Autonomy and/or Performance includes 4 schemas:

Dependence/Incompetence

Vulnerability to Harm or Illness

Enmeshment/Undeveloped Self

Failure

A broad, pervasive theme; Regarding oneself and one's relationships with others; **AKA Lifetraps**
Developed during childhood and elaborated throughout one's lifetime and Dysfunctional to a significant degree

Result from an interplay of temperament with everyday noxious experiences as a child with parents, siblings, or peers
Capable of generating high levels of disruptive affect, extremely self-defeating consequences; and/or significant harm to others
Capable of interfering significantly with meeting core needs for autonomy, connection, self expression, etc.

SCORING KEY

1 Completely untrue of me
2 Mostly untrue of me
3 Slightly more true than untrue of me
4 Moderately true of me
5 Mostly true of me
6 Describes me perfectly

If you have any 5's or 6's on this questionnaire, this lifetrap may still apply to you, even if your score is in the low range.

SCORE	DESCRIPTION
	1. I worry a lot that the people I love will die or leave me.
	2. I cling to people because I am afraid they will leave me.
	3. I do not have a stable base of support.
	4. I keep falling in love with people who cannot be there for me in a committed way.
	5. People have always come and gone in my life.
	6. I get desperate when someone I love pulls away.
	7. I get so obsessed with the idea that my lovers will leave me that I drive them away.
	8. The people closest to me are unpredictable. One minute they are there for me and the next minute they are gone.
	9. I need other people too much.
	10. In the end, I will be alone.
	YOUR TOTAL SCORE (Add your scores together for questions 1–10)

EARLY MALADAPTIVE SCHEMA

Impaired Limits includes 2 schemas:

Entitlement/Grandiosity

Insufficient Self-Control and/or Self-Discipline

Other-Directedness includes 3 schemas:

Subjugation

Self-Sacrifice

Approval-Seeking/Recognition-Seeking

Overvigilance/Inhibition includes 4 schemas:

Negativity/Pessimism

Emotional Inhibition

Unrelenting Standards/Hypercriticalness

Punitiveness

COPING STYLES

A person's behavioral responses to schemas.

1) Avoidance (flight)

2) Surrender (freeze)

3)Overcompensation (fight or counterattack)

E.g., **defectiveness**

E.g., **abandonment**

Defectiveness schema: A person using an avoidance coping style might avoid situations that make them feel defective, or might try to numb the feeling with addictions or distractions. A person using a surrender coping style might tolerate unfair criticism without defending themself. A person using the counterattack/overcompensation coping style might put extra effort into being superhuman/perfectionistic
Abandonment example: having imagined a threat of abandonment in a relationship and feeling sad and panicky, a person using an avoidance coping style might then behave in ways to limit the closeness in the relationship to try to protect themself from being abandoned. The resulting loneliness or even actual loss of the relationship could easily reinforce the person's *Abandonment* schema

SCHEMA MODES

Mind states that cluster schemas and coping styles into a temporary "way of being" that a person can shift into occasionally or more frequently

e.g., **Vulnerable Child**: likely be a state of mind encompassing schemas of *Abandonment*, *Defectiveness*, *Mistrust/Abuse;* and a coping style of surrendering (to the schemas).

For example, a *Vulnerable Child* mode[4] might be a state of mind encompassing schemas of *Abandonment*, *Defectiveness*, *Mistrust/Abuse* and a coping style of surrendering (to the schemas).

COMMON MODES IN BPD

The Vulnerable/Abandoned Child

The Angry Child

The Punitive Parent

The Detached Protector

The Healthy Adult (Healthy Self)

The four categories are: Child modes, Dysfunctional Coping modes, Dysfunctional Parent modes, and the *Healthy Adult* mode. The four Child modes are: *Vulnerable Child*, *Angry Child*, *Impulsive/Undisciplined Child*, and *Happy Child*. The three Dysfunctional Coping modes are: *Compliant Surrenderer*, *Detached Protector*, and *Overcompensator*. The two Dysfunctional Parent modes are: *Punitive Parent* and *Demanding Parent*.

THE ABANDONED CHILD

mode in which a client may feel defective in some way, thrown aside, unloved, obviously alone, or may be in a "me against the world" mindset. The patient may feel as though peers, friends, family, and even the entire world have abandoned them. Behaviors may include falling into major depression, pessimism, feeling unwanted, feeling unworthy of love, and perceiving personality traits as irredeemable flaws. Rarely, a patient's self-perceived flaws may be intentionally withheld on the inside; when this occurs, instead of showing one's true self, the patient may appear to others as "egotistical", "attention-seeking", selfish, distant, and may exhibit behaviors unlike their true nature. The patient might create a narcissistic alter-ego/persona in order to escape or hide the insecurity from others. Due to fear of rejection, of feeling disconnected from their true self and poor self-image, these patients, who truly desire companionship/affection, may instead end up pushing others away.

THE ANGRY CHILD

Angry Child is fueled mainly by feelings of victimization or bitterness, leading towards negativity, pessimism, jealousy, and rage. While experiencing this schema mode, a patient may have urges to yell, scream, throw/break things, or possibly even injure themself or harm others. The *Angry Child* schema mode is enraged, anxious, frustrated, self-doubting, and feels unsupported.

THE PUNITIVE PARENT

Beliefs that they should be harshly punished, perhaps due to feeling "defective", or making a simple mistake; may feel that they should be punished for even existing. Sadness, anger, impatience, and judgment are directed ‘to self from self’. The *Punitive Parent* has great difficulty in forgiving themself even under average circumstances in which anyone could fall short of their standards. The *Punitive Parent* does not wish to allow for human error or imperfection, thus punishment is what this mode seeks.

THE DETACHED PROTECTOR

Detached Protector is based in escape. Patients in *Detached Protector* schema mode withdraw, dissociate, alienate, or hide in some way. This may be triggered by numerous stress factors or feelings of being overwhelmed. When a patient with insufficient skills is in a situation involving excessive demands, it can trigger a *Detached Protector* response mode. Stated simply, patients become numb in order to protect themselves from the harm or stress of what they fear is to come, or to protect themselves from fear of the unknown in general.

THE HEALTHY ADULT

Healthy Adult is the mode that schema therapy aims to help a patient achieve as the long-lasting state of well-being. The *Healthy Adult* is comfortable making decisions, is a problem-solver, thinks before acting, is appropriately ambitious, sets limits and boundaries, nurtures self and others, forms healthy relationships, takes on all responsibility, sees things through, and enjoys/partakes in enjoyable adult activities and interests with boundaries enforced, takes care of their physical health, and values themself. In this schema mode the patient focuses on the present day with hope and strives toward the best tomorrow possible. The *Healthy Adult* forgives the past, no longer sees themself as a victim (but as a survivor), and expresses emotions in ways which are healthy and cause no harm.

TREATMENT GOALS

Encourage assumption that (maladaptive) schemas are either incorrect or greatly exaggerated

Emotional processing of 'schema developing' early experiences

Reduce dysfunctional modes (showing ultimate unhelpfulness)

Define and support the healthy adult side to develop so that the dysfunctional coping modes are less necessary

TREATMENT PROCESSES

Cognitive strategies expand on standard CBT such as listing pros and cons of a schema, testing the validity of a schema, or conducting a dialogue between the "schema side" and the "healthy side".

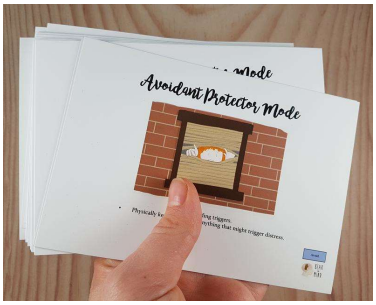
***Experiential and emotion focused*:** expand on standard Gestalt therapy; use psychodrama, empathetic confrontation, and imagery rescripting techniques.

Behavioral: pattern-breaking strategies such as role playing an interaction and then assigning as homework; event scheduling, exposure.

Use of therapeutic relationship central: "limited re-parenting".

Also Flash cards and *schema diary or logbook*

Gestalt Psychodrama:
Role plays & exercises designed to illicit emotional responses to work on congruence & integration
Empathetic confrontation
Empty Chair to promote awareness & integration
Address unfinished business to gain insight, awareness and address past issues
Bring attention to non-verbals and their meaning
Explore how past influences relations within / outside therapy context



Logbook for schema triggering and mode analysis

The event that upset me

Feelings, emotions	***Thoughts*** *(try to relate each thought to a feeling)*

Behaviour *(What did I do?)*

Early Maladaptive Schemas: *Which ones were triggered?*

Modes: *What mode(s) was/were active in the situation? ✔ those you recognize and describe them.*

Child	*Vulnerable*	*Angry/impulsive*
Parent	*Demanding*	*Punitive*
Coping	*Detached protector*	*Detached self-soother*
	"Poor me"/self pity	*Compliant surrenderer*
	Overcontroller(s)	*Other*

What part of my reaction was justified (Healthy Adult mode)?

Overreaction: *What part of my reaction was too strong?*

If so, In what way did I misinterpret the situation (cognitive distortions)?

What was the effect of switching into the different modes?

Healthy Adult response: *What would be a better way for me to view this situation and deal with it? What could I do to solve this problem in a better way?*

Feeling *(What do I feel about the situation now that I have been through this worksheet?)*

RESEARCH – SCHEMA FOR BPD

Arnoud **Arntz, Netherlands, 2004**: In-patient BPD approx. 50% 'full recovery'and 70% achieving "clinically significant and relevant improvement", relatively low drop-out high intensity, long duration 3 + 1 year) 70% achieving "clinically significant and relevant improvement".

Arntz, Netherlands 2006: Out-patient lower intensity/duration, similar effectiveness and similarly low dropout rates.

Farrell, Shaw and Webber, USA, 2014: 30 session schema therapy **group** in addition to DBT; dropout DBT + Schema = 0%, BPD only = 25%; no longer met BPD diagnostic criteria DBT + Schema = 94%, DBT only = 16%.

Outcome studies on schema therapy[edit]

Schema therapy vs transference focused psychotherapy outcomes[edit]

Dutch investigators, including Josephine Giesen-Bloo and Arnoud Arntz, compared schema therapy with transference focused psychotherapy (TFP) in the treatment of borderline personality disorder. 86 patients were recruited from four mental health institutes in the Netherlands. Patients in the study received two sessions per week of SFT or TFP for three years. After three years, full recovery was achieved in 45% of the patients in the SFT condition, and in 24% of those receiving TFP. One year later, the percentage fully recovered increased to 52% in the SFT condition and 29% in the TFP condition, with 70% of the patients in the SFT group achieving "clinically significant and relevant improvement". Moreover, the dropout rate was only 27% for SFT, compared with 50% for TFP.

Patients began to feel and function significantly better after the first year, with improvement occurring more rapidly in the SFT group. There was continuing improvement in subsequent years. Thus investigators concluded that both treatments had positive effects, with schema therapy clearly more successful.[19]

Less intensive outpatient, individual schema therapy[edit]

Dutch investigators, including Marjon Nadort and Arnoud Arntz, assessed the effectiveness of schema therapy in the treatment of borderline personality disorder

when utilized in regular mental health care settings. A total of 62 patients were treated in eight mental health centers located in the Netherlands. The treatment was less intensive along a number of dimensions including a shift from twice weekly to once weekly sessions during the second year. Despite this, there was no lessening of effectiveness with recovery rates that were at least as high and similarly low dropout rates.[20]

Pilot study of group schema therapy for borderline personality disorder[edit]

Investigators Joan Farrell, Ida Shaw and Michael Webber at the Indiana University School of Medicine Center for BPD Treatment & Research tested the effectiveness of adding an eight-month, 30-session schema therapy group to treatment-as-usual (TAU) for borderline personality disorder (BPD) with 32 patients. The dropout rate was 0% for those patients who received group schema therapy in addition to TAU and 25% for those who received TAU alone. At the end of treatment, 94% of the patients who received group schema therapy in addition to TAU compared to 16% of the patients receiving TAU alone no longer met BPD diagnostic criteria. The schema therapy group treatment led to significant reductions in symptoms and global improvement in functioning. The large positive treatment effects found in the group schema therapy study suggest that the group modality may augment or catalyze the active ingredients of the treatment for BPD patients.[21] As of 2014, a collaborative randomized controlled trial is under way at 14 sites in six countries to further explore this interaction between groups and schema therapy.[22]

CONCLUSION

Questions / Comments/ Sharing ?