Arnoud Arntz | Hannie Van Genderen

Schema Therapy for Borderline Personality Disorder

Second Edition

WILEY Blackwell

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Contents

About the Authors

Between 1987 and 2014 **Arnoud Arntz** (Professor of Clinical Psychology and Experimental Psychopathology at Maastricht University and clinical psychologist) and Hannie van Genderen MPhil, (clinical psychologist, psychotherapist, and Supervisor of the International Society of Schema Therapy (ISST) and the Dutch Association for Behavioral and Cognitive Therapy) worked together at the Riagg Maastricht. They were involved there in numerous studies in the field of anxiety disorders and personality disorders. Arnoud Arntz was project leader of the Dutch multi-center trial comparing schema therapy with transference-focused psychotherapy. One of his main research interests is borderline personality disorder.

Since 2014, Arnoud Arntz has been Professor of Clinical Psychology at the University of Amsterdam. He is, together with Joan Farrell, Principal Investigator of the international trial comparing two forms of group schema therapy for borderline to each other and to optimal treatment as usual. He practices as a clinical psychologist at the PsyQ mental health center in Amsterdam.

Hannie van Genderen has worked since 2016 as a clinical psychologist in her own private practice. Since 2000 she has been the Director of "Schematherapieopeidingen" a Dutch Institute for Schema Therapy that organizes standard and advanced level international certification training programs in schema therapy (individual for adults, children and adolescents, and group therapy). In addition to training in schema therapy for borderline personality disorder, specialized training courses on Cluster C, workshops on Imagery Rescripting, Chairwork, Angry Modes, Depression, The Healthy Adult, and Narcissitic Personality Disorder are offered (see www.schematherapieopleidingen.nl).

Preface

Schema therapy is a relatively new integrative psychotherapy based on cognitive models and offers an effective treatment of borderline personality disorder (BPD). Several trials have now documented its effectiveness and cost-effectiveness compared to psychodynamic treatment and treatment as usual. Moreover, dropout from treatment is consistently low, indicating that schema therapy is well accepted by patients.

This book offers a practical guide for therapists to conduct schema therapy with BPD patients. Building upon Jeffrey Young's schema mode model, Young's schema therapy, and insights from Beckian cognitive therapy and experiential methods, it offers a conceptual model of BPD, a treatment model, and a wealth of methods and techniques for treating BPD patients. The treatment not only addresses the DSM BPD criteria-related problems, but also the psychopathological personality features underlying the symptoms, like attachment problems, punitive conscience, inadequately processed childhood traumas and so on. Research has demonstrated that patients improve in all these aspects, including on the level of automatic information processing.

The authors equate their treatment to blind simultaneous chess playing in a pinball machine, meaning that the therapist has to be actively aware of the abundance of quickly changing factors that play a role in the patient's problems, and simultaneously has to address them. Though treatment of BPD is complicated, many therapists can learn this method. Experienced therapists with good stamina will feel supported and stimulated by the book's practical explanations and examples. Central in the therapeutic relationship is the concept of "limited reparenting," which forms the basis for a warm and collaborative relationship. A good therapeutic relationship is not enough, however. Therefore, numerous experiential, interpersonal, cognitive and behavioral methods and techniques are described that are specifically suited

for the treatment of BPD patients. Finally, the book offers specific methods to be used in the treatment of very difficult cases and helps the therapist to deal with the many pitfalls that can arise from the treatment of BPD.

Since the publication of the first edition of this book in 2009 several important developments took place in schema therapy. Moreover, from teaching schema therapy we learned about bottlenecks that participants encountered in applying the treatment. We also realized that the general approach and the techniques change throughout the different stages of therapy. This necessitated a thorough revision. In this new edition we have revised the text so that new insights and methods are integrated. This revised approach leads to a speeding up of treatment, without loss of effectiveness. The new edition describes how techniques should be adapted to the phase of therapy. We also discuss new approaches related to the application of schema therapy in groups, couples, and youths. The latest research findings and their implications for clinical practice are discussed, and the theoretical underpinnings of the schema mode model are now more extensively covered. We treat more schema modes now, as many patients present with additional modes than covered by the basic mode model of BPD, and the clinician should know how to handle these. Lastly, we now refer to fragments of the audiovisual production "step by step" illustrating the different techniques.

Acknowledgments

The writing of a book combined with a busy job at the Maastricht Community Mental Health Centre demanded much time, which I managed to find thanks to the unconditional support of my late husband Leo Scheffer. He not only took over much of the care of the family but also helped me with reading and typing out the texts. I thank my children Sacha and Zoë for their patience as they heard "not now" many times during this period.

I learned the treatment of patients with personality disorders thanks to the many training opportunities organized by Arnoud Arntz from Maastricht University, by inviting, among others, Tim Beck, Cory Newman, Jeffrey Young, Christine Padesky, Kathleen Mooney, Joan Farrell and Ida Shaw. However, I especially learned a great deal from Arnoud himself, through his enthusiasm and assertiveness in continuously discovering new ways to treat "untreatable" patients, just like the ones with borderline personality disorder.

I would like to thank my colleagues from RIAGG Maastricht, particularly Arnoud Arntz, Tonny van Gisbergen and Wiesette Krol from the Borderline peer supervision group, for their collaboration and support while learning to treat patients with borderline personality disorder. Marjon Nadort, Marleen Rijkeboer and Remco van der Wijngaart I want to thank for years of collaboration: with them I have given the majority of courses and workshops. Together we have always found better ways to teach schema therapy to colleagues.

I am also indebted to my colleagues Monique Wijers, Monique Auerbach, Ina Krijgsman and my brother-in-law Igor van de Wal as they have read the whole book, asked wise questions and suggested additions.

The patients I have treated may have contributed most to this book. Examples in this book are (anonymously) taken from our conversations,

and I have learned a lot from them. The diagnosis of borderline personality disorder is unfortunately not yet accepted to the extent that I could list their names here. But my heartfelt thanks to you.

Hannie van Genderen

Without my teachers, one of them the co-author of this book, I should have never reached the point of treating people with borderline personality disorder. I am very grateful for this. I would like to give my special thanks to Tim Beck, Christine Padesky, Kathleen Mooney, Cory Newman, Joan Farrell, and Ida Shaw, and particularly Jeffrey Young for what they taught our team in their workshops. Jeffrey Young in particular deserves my thanks, as he developed a model that not only matched with my own early thinking about borderline personality disorder, but also developed a comprehensive treatment, which is the subject of this book. My therapist and research colleagues, among whom are my former PhD candidates Laura Dreessen, Anoek Weertman, Simkje Sieswerda, Joos Bloo, Thea van Asselt, Marjon Nadort, Lotte Bamelis and Jill Lobbestael, I also want to thank for the help they provided with developing the treatments and the research into borderline personality disorder. Moreover, I would like to thank the research assistants and interns who have conducted many studies, and especially the patients who have taken part in the treatment and the research, without whom we could not have gained insight into these complex problems and their treatment.

Ultimately, this book could not have come about without the opportunities offered by the Maastricht Community Mental Health Centre to the academic project of the Research Institute of Experimental Psychopathology of the Maastricht University, as well as the grants from the Dutch National Fund for Mental Health and the Fund for Developmental Medicine by the College for Care Insurances. Their grants enabled the training of the therapists for the multi-center trial into treatments of borderline personality disorder and the conducting of this study, which empirically tested the effectiveness and cost-effectiveness of the treatment outlined in this book.

Thanks are due to Kyra Sendt and Jolijn Drost for their help with translating the original Dutch book into the first English edition.

Arnoud Arntz

Introduction

Until recently, patients with borderline personality disorder (BPD) were known as particularly difficult patients. They were viewed as patients who either could not be helped by therapy or, in the best-case scenario, showed low success rates to treatment. Meanwhile, their demands on both medical and mental health care are great and their dropout rates from treatment programs are high.

In this book we describe a treatment for patients with BPD, which, in most cases, leads to recovery from this disorder or substantial clinical improvement. Schema therapy (ST) not only leads to a reduction in BPD symptoms, but also to lasting changes in the patient's personality.

In Chapter 1, BPD is defined and described, followed by a discussion of the development of this disorder.

Chapter 2 gives an explanation of ST for BPD, developed by Jeffrey Young. The treatment is based on the schema mode model. The different schema modes for patients with BPD are described in this chapter.

In Chapter 3 we explain the aims and different phases of the therapy.

Chapters 4–8 discuss different treatment methods and techniques. Chapter 4 involves seeing the therapeutic relationship as an instrument of change. Also the essential concept of "limited reparenting," a central point of ST, is discussed at length.

Schema Therapy for Borderline Personality Disorder, Second Edition.
Arnoud Arntz and Hannie van Genderen.

Chapter 5 describes experiential techniques that use experiencing to bring about change. These techniques are: imagery rescripting; role playing; the two-or-more-chair technique; and experiencing and expressing feelings.

The cognitive techniques used in this book are described and explained in Chapter 6. As there is a great deal of literature about these techniques, they are only briefly defined. This is also the case for the behavioral techniques described in Chapter 7.

Chapter 8 deals with a number of specific therapeutic methods and techniques. While these are not relevant for all BPD patients, they can be important and useful for specific patients and applications.

Chapter 9 explains which techniques are the most appropriate to each schema mode. The art of addressing different modes in a single session is also discussed in this chapter.

The latest developments in the field of ST are explained in Chapter 10. In particular, Group-ST, and ST with couples where one of the two partners has BPD, are discussed. We also briefly discuss the application of ST in day treatment and inpatient settings, the use of nonverbal therapies as adjunct to ST, and the application of ST for children and youths, and older people.

Chapter 11 deals with the final phase of therapy during which the patient no longer has BPD, but perhaps retains some of the personality characteristics and/or coping strategies, which could stand in the way of further positive changes.

Chapter 12 contains the summary and conclusion.

Considering that a large percentage of BPD patients are female, the authors refer to the patient in the feminine form. Although many therapists are female, for the sake of clarity the authors refer to the therapist using the masculine form.

1

Borderline Personality Disorder

What Is Borderline Personality Disorder?

Patients with borderline personality disorder (BPD) have problems with almost every aspect of their lives. They have problems with constantly changing moods, their relationships with others, unclear identities, and impulsive behaviors. Outbursts of rage and crises are commonplace. Despite the fact that many BPD patients are intelligent and creative, they seldom succeed in developing their talents. Often their education is incomplete, and they remain unemployed. If they work, it is often at a level far below their capabilities. They are at a great risk of self-harm by means of self-injury and/or substance abuse. The suicide risk is high and approximately 10% die as a result of a suicide attempt (Paris, 1993).

In this book, the DSM-5 diagnostic criteria for BPD are used for the diagnosis of BPD and not the psychoanalytical definition of the borderline personality organization (Kernberg, 1976, 1996; Kernberg, Selzer, Koenigsberg, Carr, & Applebaum, 1989). The borderline personality organization includes a number of personality disorders and axis-I disorders and is therefore far too extensive for the specific treatment for BPD that will be described here. According to the DSM-5, patients must satisfy at least five of the nine criteria, as listed in Table 1.1, to obtain a diagnosis of BPD. The essential general feature of the DSM-5 definition of BPD is *instability* and its influence on the areas of interpersonal relationships, self-image, feelings, and impulsiveness.

Schema Therapy for Borderline Personality Disorder, Second Edition.
Arnoud Arntz and Hannie van Genderen.

Table 1.1 DSM-5 diagnostic criteria for borderline personality disorder

A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

1. Frantic efforts to avoid real or imagined abandonment. (Note: Do not include suicidal or self-mutilating behavior covered in criterion 5.)
2. A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation.
3. Identity disturbance: markedly and persistently unstable self-image or sense of self.
4. Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating). (Note: Do not include suicidal or self-mutilating behavior as covered in criterion 5.)
5. Recurrent suicidal behavior, gestures or threats, or self-mutilating behavior.
6. Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability or anxiety usually lasting a few hours and only rarely more than a few days).
7. Chronic feelings of emptiness.
8. Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights).
9. Transient, stress-related paranoid suicidal ideation or severe dissociative symptoms.

Source: After: American Psychiatric Association (APA, 2013) DSM-5.

Prevalence and Comorbidity

BPD is one of the most common mental disorders within the (outpatient and inpatient) clinical population. Prevalence in the general population is estimated at 1.1–2.5% and varies in clinical populations depending on the setting, from 10% of the outpatients up to 20–50% of inpatients. However, in many cases the diagnosis of BPD is made late or not given at all. This might be due to the high comorbidity and other problems associated with BPD, which complicate the diagnostic process.

The comorbidity in this group of patients is high and diverse. On axis-I, there is often depression, eating disorders, social phobia, PTSD, or relationship problems. In fact one can expect any or all of these disorders in stronger or weaker forms along with BPD.

All of the personality disorders can be co-morbid to BPD. A common combination is that of BPD along with avoidant, dependent, narcissistic, antisocial, histrionic, and paranoid disorders (Layden, Newman, Freeman, & Morse, 1993).

Reviews and studies by Dreessen and Arntz (1998), Mulder (2002), and Weertman, Arntz, Schouten, and Dreessen (2005) have shown that anxiety and mood disorders are treatable when the patient has a comorbidity with a personality disorder. However, in the case of BPD, one must be careful to only treat the axis-I disorder. BPD is a serious disorder that results in permanent disturbance of the patient's life with numerous crises and suicide attempts, which makes the usual treatment of axis-I disorders burdensome. Axis-I complaints and symptoms often change in nature and scope, making the diagnostic process even more difficult. This often results in the treating of BPD taking priority. Disorders that should take priority over BPD in treatment are described in "(Contra-) Indications" (see Chapter 2).

Development of BPD

The majority of patients with BPD have experienced sexual, physical, and/or emotional abuse, and emotional neglect in their childhood; sexual abuse in particular between the ages of 6 and 12 (Herman, Perry, & van der Kolk, 1989; Hernandez, Arntz, Gaviria, Labad, & Gutiérrez-Zotes, 2012; Lobbestael, Arntz, & Bernstein, 2010; Ogata et al., 1990; Weaver & Clum, 1993). It is more problematic to identify emotional abuse and neglect in BPD patients than to identify sexual or physical abuse. Emotional abuse and neglect often remains hidden or not acknowledged by the BPD patient out of a sense of loyalty toward the parents or due to a lack of knowledge of what a normal, healthy childhood involves. These patients don't know what they missed, because they never experienced feelings of being loved, accepted, and cared for. When someone tries to give them love and acceptance later in life, they sometimes react negatively toward that person (i.e., the therapist).

These traumatic experiences in combination with temperament, insecure attachment, developmental stage of the child, as well as the social situation in which things took place, result in the development of dysfunctional interpretations of the patient's self and others (Arntz, Weertman, & Salet, 2011; Zanarini, 2000). Patients with BPD have a disorganized attachment style. This is the result of the unsolvable situation they experienced as a child, in which their parent was both a menace or threat, as well as a potential safe haven (van IJzendoorn, Schuengel, & Bakermans-Kranenburg, 1999). Translated into cognitive terms, a combination of dysfunctional schemas and coping strategies results in BPD (e.g., Arntz et al., 2011).

Patients with BPD have a very serious and complex set of problems. Because the patient's behavior is so unpredictable, it exhausts the sympathy

and endurance of family and friends. Life is not only difficult for the patients, but also for those around them. At times, life is so difficult that the patient gives up (suicide) or her support system gives up and breaks off contact with the patient. Treating BPD patients is often also fatiguing for the mental health care giver, especially in the absence of effective treatment methods. The good news is that effective treatments have been developed the last decades, and schema therapy is one of the most successful.

Schema therapy offers BPD patients and therapists a treatment model in which the patient is helped to break through the dysfunctional patterns she has created and to achieve a healthier life. The model helps patients and therapists to understand how early childhood experiences are related to the present problems and offers grip on the otherwise overwhelming and difficult to understand problems. Treating BPD patients with schema therapy makes it relatively easy to comprehend the patient's dysfunctional behavior and it gives the therapist many tools to treat the patient.

2

Schema Therapy for Borderline Personality Disorder

The Development of Schema Therapy for Borderline Personality Disorder

Before the development of specialized psychotherapies for BPD, such as schema therapy (ST), BPD was treated primarily from a psychoanalytical perspective. This started to change in the late 1980s when cognitive behaviorists began to study the treatment of personality disorders with cognitive behavioral therapy, and psychodynamic therapists started to develop variants of psychodynamic therapy that were specifically adapted to BPD.

The most important early developments in specialized psychotherapies for BPD that emerged in this era were the formulation and empirical validation of Dialectical Behavior Therapy (DBT; Linehan, Armstrong, Suarez, Allmon, & Heard, 1991; Linehan, 1993), the development of Transference-Focused Psychotherapy (TFP) (Kernberg, Selzer, Koenigsberg, Carr, & Applebaum, 1989), the development of Mentalization Based Treatment (MBT, Bateman & Fonagy, 2004), and the development of cognitive therapy for personality disorders. The use of cognitive therapy for treating personality disorders was first introduced by Aaron Beck, Arthur Freeman, and colleagues in their work *Cognitive Therapy of Personality Disorders* (1990). In that same year, Jeffrey Young introduced a new form of cognitive therapy, which he referred to as "Schema-Focused Therapy," later "Schema Therapy" (Young, 1990, 1994). He later expanded upon this therapeutic model with the introduction

Schema Therapy for Borderline Personality Disorder, Second Edition.
Arnoud Arntz and Hannie van Genderen.

of schema modes (Young, Klosko, & Weishaar, 2003). His theory is based upon a combination of insights derived from cognitive, behavioral, psychodynamic, humanistic, and developmental (including attachment) theories. The actual treatment is mainly based on cognitive behavioral therapy and techniques derived from experiential therapies. There is a strong emphasis on the therapeutic relationship which is used as a means to bring about change, as well as on the emotional processing of traumatic experiences.

To date, ST appears to be a good method to achieve substantial personality improvements in BPD patients.

Research Results

Research on traditional psychoanalytical forms of treatment showed high dropout percentages (46–67%) and a relatively high percentage of suicide. Across four longitudinal studies, approximately 10% of the patients died during treatment or within 15 years following treatment due to suicide (Paris, 1993). This percentage is comparable to that of nonpsychotherapeutically treated BPD patients (8–9%: as reported by Adams, Bernat, & Luscher, 2001).

The first controlled study of cognitive behavioral treatment for BPD was realized by Linehan et al. (1991). The DBT they introduced had lower dropout rates, fewer hospitalizations, and a greater reduction in self-injury and suicidal behavior in comparison with usual treatment. On other measurements of psychopathology, there were no significant differences when compared with usual treatment. Uncontrolled studies as to the effectiveness of Beck's cognitive therapy also showed a reduction in suicide risk and depressive symptoms, as well as a decrease in the number of BPD symptoms (Arntz, 1999; Beck, 2002; Brown, Newman, Charlesworth, Crits-Christoph, & Beck, 2004). Moreover, the dropout rates during the first year were lower than normal (about 9%).

The first controlled study testing ST as developed by Young was conducted in the Netherlands, where ST was compared to TFP, a psychodynamic method from Kernberg and co-workers (Giesen-Bloo et al., 2006). This study started in 2000 and involved 3 years of treatment. ST showed more positive results than TFP in reduction of BPD symptoms, as well as other aspects of psychopathology and quality of life. In the follow-up study, 4 years after the start of the treatment, 52% of the patients who started ST recovered from BPD, compared to 29% in TFP, while more than two-thirds of ST participants showed

clinically significant improvement in reducing BPD symptoms, compared to 52% in TFP. These percentages are impressive given that dropouts (even those due to somatic illness) were included in the study.

One of the most compelling results from this first randomized clinical trial (RCT) was that *all* BPD problems were reduced and not only conspicuous symptoms such as self-harm. For instance, the patient's quality of life as a whole and her feeling of self-esteem improved significantly. Thus, as a result of ST, all psychopathological characteristics of BPD, whether symptomatic or personality related, significantly improved. Similar results were found in a Norwegian series of case studies. When patients were measured post-treatment, 50% no longer met the criteria for BPD and 80% appeared to have notably profited from the treatment (Nordahl & Nysæter, 2005).

Despite the high treatment costs, this first RCT on ST also demonstrated that ST is cost-effective, as evidenced by a cost-effectiveness analysis showing that ST is not only superior to TFP in effects, but also less costly. Moreover, compared with baseline, ST leads to a reduction of societal costs for BPD patients, so that the net effect was a reduction of costs, despite the costs involved in delivery of ST (van Asselt et al., 2008).

The question whether ST has similar effects when implemented in clinical practice was addressed in a study by Nadort et al. (2009). Results indicated that effectiveness and treatment retention were similar to those of the Giesen-Bloo et al. (2006) trial. The study also addressed the issue whether therapists should provide a phone number that patients could use when in crisis outside office hours, as was originally prescribed by the protocol. As the results did not yield any evidence for a positive effect of this, providing such a phone contactability was deleted from the protocol. As will be seen, giving patients an email address that they can use to share experiences with their therapist outside office hours, without any obligation of therapists to respond immediately, has replaced the phone contactability.

There have been several studies completed now on ST for BPD (see Jacob & Arntz, 2013 and Sempertegui, Karreman, Arntz, & Bekker, 2013, for reviews), including studies on group-ST (Farrell, Shaw, & Webber, 2009), the combination of individual and group-ST (Dickhaut & Arntz, 2014; Fassbinder et al., 2016), and inpatient ST (Reiss, Lieb, Arntz, Shaw, & Farrell, 2014). Taken together, these studies indicate low dropout from treatment and high effectiveness of ST, that is not limited to BPD-symptom reduction, but includes better social and societal functioning, better quality of life, and increased happiness. When dropout from ST for BPD is compared to other treatments, a multilevel survival meta-analysis indicated

that the dropout percentages reported so far in ST studies are remarkably smaller than those from other treatments (Arntz et al., 2020). The effectiveness of ST on measures of BPD-severity and specific BPD-traits is also high and the effect sizes tend to be significantly higher than in other treatments (Rameckers et al., 2020). However, so far only one larger RCT has been published that compared ST to another treatment (Giesen-Bloo et al., 2006). It is necessary that more RCTs compare ST to other treatments, including treatment as usual and other specialized psychotherapies. One large international study comparing the combination of individual and group-ST, group-ST, and (optimal) treatment as usual for BPD was just completed when this book was finalized. The preliminary results indicated that ST was superior to treatment as usual in primary and secondary outcomes, and that especially the combined individual–group format was effective and associated with the highest treatment retention (Wetzelaer et al., 2014; Arntz et al., 2019). Another study that is currently underway is a German study comparing the combination of individual and group-ST to DBT as treatments for BPD (Fassbinder et al., 2018). Both RCTs include not only focus on effectiveness, but also study cost-effectiveness and experiences of patients.

What makes ST so acceptable for patients and what might explain its effectiveness? Qualitative studies into the views of patients and therapists have yielded some suggestions (de Klerk, Abma, Bamelis, & Arntz, 2017; Tan et al., 2018). First, the schema mode model is often mentioned as very helpful, offering both patients and therapists an easy to understand model of the patient's problems. This offers a meta-cognitive understanding to patients and helps therapists to choose the right technique. Second, the therapeutic relationship, more specifically limited reparenting, is mentioned as particularly helpful. Third, experiential techniques are mentioned as particularly powerful. Fourth, on a more general level, the ST approach that focuses on deeper levels than symptoms and skills, linking developmental experiences and life-long patterns to problems in the present, and addressing the historical roots of the patient's problems, is appreciated. Lastly, patients don't mention specific issues that are not focused on enough in ST, this in contrast to the findings by Katsakou et al. (2012), who concluded that patients found the focus of DBT and MBT too limited. However, some patients criticized that the newer ST models start to reduce session frequency in year 2, and stop treatment after 2 years, which is often viewed as too early. As to the comparison of group-ST to the combination of individual and group-ST, patients and therapists tend to favor the latter (from the results of

the quantitative analysis of the international RCT we will learn whether this tendency is supported by treatment retention and effectiveness results).

To summarize, the results of empirical studies indicated that ST is a highly acceptable and effective treatment, which is cost-effective despite its relative high intensity.

(Contra-) Indications

There are certain disorders that can complicate the diagnosis of BPD, in particular bipolar disorder, psychosis (this refers to psychotic disorder, not a short-term and reactive psychotic episode, which often occurs in BPD patients), and ADHD. The presence of these disorders complicates not only the diagnosis but might also interfere with treating BPD. However, if these disorders are very prominent, they will be the primary diagnosis, and BPD will be usually viewed as a secondary comorbidity. Usually these disorders have to be addressed first, before it is possible to focus on treating BPD.

Specific comorbid disorders, even if they are not viewed as primary, must be addressed before ST can be considered for BPD. These include very severe major depression, severe substance dependency in need of clinical detoxification, and anorexia nervosa. In addition, developmental disorders such as autism spectrum disorders require adaptation of ST. Recently therapists who work with these patients reported that they do have success with treating personality disorders with modified ST in this group when the autistic problems are not too severe. Research on ST for people with the combination of an autism spectrum disorder and a personality disorder has been conducted (Vuijk & Arntz, 2017). It should be stressed that the aim of such applications of ST is *not* to treat the autism spectrum disorder, but rather the personality disorder problems.

In the study by Giesen-Bloo et al. (2006), antisocial personality disorder was also excluded. This was insisted upon by the TFP experts. However, pilot studies using ST with antisocial personality disorder have shown positive results, as an RCT comparing ST to treatment as usual in high security forensic hospitals, indicating ST can be an effective treatment for these patients (Bernstein, Arntz, & de Vos, 2007; Bernstein et al., 2020). However, for group application of ST for BPD, the inclusion of patients with specific comorbid antisocial personality traits might constitute a risk, if these patients cannot control their aggressive impulsive and act out in unpredictable ways to other group members. Thus, a history of recent lack of control

over interpersonal physical aggression might be a contraindication for group-ST for BPD. Similarly, specific narcissistic traits, manifested as poorly controlled denigrating others, are a risk for group-ST.

Rationale of Treatment/Theories Supporting Treatment

ST as described by Young states that everyone develops schemas during childhood. A schema is an organized knowledge structure, which develops during childhood and manifests in certain behaviors, feelings, and thoughts (Arntz, 2018; Arntz & Lobbestael, 2018). While a schema is not directly measurable, it can be gauged by analyzing the patient's life history and observing the manner in which she deals with her temperament and talents. This becomes more evident and observable as the patient shares more details about her behavior in various social situations and the life rules and strategies to which she adheres.

Healthy schemas develop when the basic needs of a child are met. This enables children to develop positive images about other individuals, themselves, and the world as a whole.

The basic needs of children include:

Safety – Children must be able to depend on a reliable adult for care and a safe place to live, develop, and grow.

Connection to others – Children must feel that they are connected to others and are able to share their experiences, thoughts, and feelings with others.

Autonomy – Children must have a safe and secure environment from where they can explore and learn about the world. The ultimate goal of maturing to adulthood is for them to eventually stand on their own two feet. Caregivers must slowly but surely allow children to separate from them in order to grow into autonomous adults.

Self-appreciation – Children must have an adequate sense of appreciation. In order to develop a strong sense of self-esteem, they must be appreciated for who they are as people and what they are capable of doing.

Self-expression – The expression of one's opinions and feelings must be learned and stimulated without being held back by strict or oppressive rules.

Realistic limits – In order to live in a society with others, it is necessary for children to learn certain rules. They must understand when to subdue their autonomy or self-expression when dealing with others and be

capable of doing so. Children also have to learn to tolerate and adequately deal with frustrations (Young & Klosko, 1994; Young et al., 2003).

When these needs are not met, whether solely due to shortcomings in the child's environment, or in combination with traumatic events (such as emotional, physical, or sexual abuse, or being bullied), this can form—in interaction with the temperament of the child—dysfunctional schemas and coping strategies (see Figure 2.1). The dysfunctional schemas that are formed during childhood development are called "early maladaptive schemas." Given the circumstances in which the child grew up, they are usually understandable (e.g., a child growing up in an environment where there is a lot of threat of abandonment has an increased risk to develop an abandonment schema). Young describes 18 different early maladaptive schemas (see Appendix I) and three groups of coping strategies (see Appendix J) (Young et al., 2003).

The schemas and coping styles form a sort of alternative for the personality disorder diagnostic system in the DSM-5 (American Psychiatric Association [APA], 2013). For BPD, so many schemas have been found that a treatment based solely on a schema conceptualization would be very complex. Moreover, the 18 schemas and three coping styles lead to 54 possible combinations, further complicating the task to understand the patient's problems with this model.

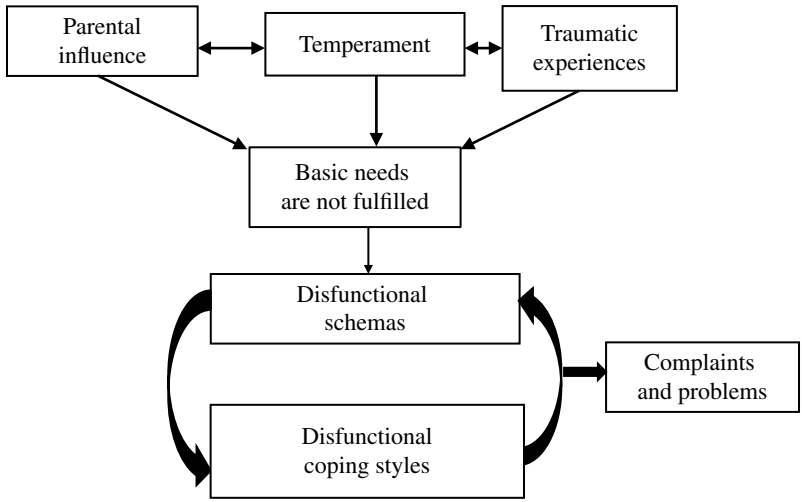

Figure 2.1 The development of dysfunctional schemas

Schema Modes

Patients with BPD often have so many different schemas present at the same time that both patient and therapist cannot see the wood for the trees. Because shifts in behavior and feelings take place so quickly, it is difficult for the patient herself, let alone for those around her, to understand what is taking place. This further exacerbates an already complex problem. These sudden shifts in patterns of feeling, thinking and behavior, which are so common in BPD, have inspired the development of the concept of a "schema mode" (also called "mode" or "schema state") (McGinn & Young, 1996). A schema mode is a set of schemas and processes, which, in certain situations, determine the thoughts, feelings, and actions of the patient at the cost of other schemas. In other words, when the BPD patient is relatively relaxed and comfortable, one sees a totally different side of her personality as opposed to when she feels threatened. Under normal circumstances, one sees a relatively quiet patient who appears to have few emotions. However, when, for example, the threat of abandonment by an important figure is posed, one sees a "young child" being very upset and completely inconsolable. A patient with BPD can switch from one strong mood or emotion to another in a very short period of time. According to the schema mode model, this is due to the patient's continual and uncontrolled shifts from one mode to the other.

It is important to understand that schema modes are related to schema's, and that there is no fundamental difference between schema theory and schema mode theory. The schema model as formulated by Young et al. (2003) states that when an early maladaptive schema is triggered, or is threatened to be triggered, people use specific ways of coping to deal with this activation, as the activation is usually experienced as highly unpleasant and signaling threat. The ways of coping are grouped in three coping styles: overcompensation, avoidance, and surrender—analogous to the primitive coping under high stress common to mammals (fight, flight, freeze). The combination of a schema that is (threatened to be) triggered and a coping response is a schema mode. In other words:

$$\text{Schema} \rightarrow \text{Coping} \rightarrow \text{Schema Mode}.$$

Two studies have actually supported this model, in that they demonstrated that coping indeed determines how modes are related to schemas (in statistical terms: the coping style mediates the relationship between

schemas and modes) (Rijkeboer & Lobbestael, 2012; van Wijk-Herbrink et al., 2018). The last study even went one step further, demonstrating that the very same early maladaptive schemas can underlie internalizing as well as externalizing psychopathology, and that it depends on the type of coping, hence the schema modes, whether a (threatened) schema activation results in internalizing or externalizing psychopathology:

Schema → Coping → Schema Mode → Psychopathological Symptom(s).

Thus, in the phase of case conceptualization (see Chapter 3) it is meaningful to combine the mode model as described below with the specific schemas that give "color" to the mode of your individual patient. When patient A is in the abandoned/abused child mode she might feel stupid (schema defectiveness/shame) and distrustful (schema mistrust/abuse) while patient B might feel abandoned (schema abandonment/instability) and dependent (schema dependence/incompetence).

Young suggested that the following five modes are characteristic of BPD: the detached protector, the abandoned/abused child, the angry/impulsive child, the punitive parent, and the healthy adult (actually, a weak healthy adult mode). Recently an extra important mode has been added to the model: the happy child mode, which is also weak in BPD. In some cases, we also see an undisciplined or impulsive child, which we will describe in combination with the angry child. These modes can be renamed to make them more applicable to the patient's situation (see Figure 2.2).

In clinical practice we advise to make a more extensive case conceptualization in which the origins of the schemas and modes in the youth and the current problems are described. In each mode the specific schema's that give "color" to the mode of your individual patient are added (see Figure 2.3 for an example).

We must strongly emphasize that this heuristic model does not infer that BPD is a multiple personality disorder. Giving names to the different modes is a means of helping the patient to better understand and identify with the mode and does not have any reference to identities or persons.

The following are descriptions of the different modes most prominent in BPD. The modes are also demonstrated in a recent audiovisual production (ST step by step, van der Wijngaart & van Genderen, 2018). Chapter 9 further describes treatment and how therapists can best address the different modes.

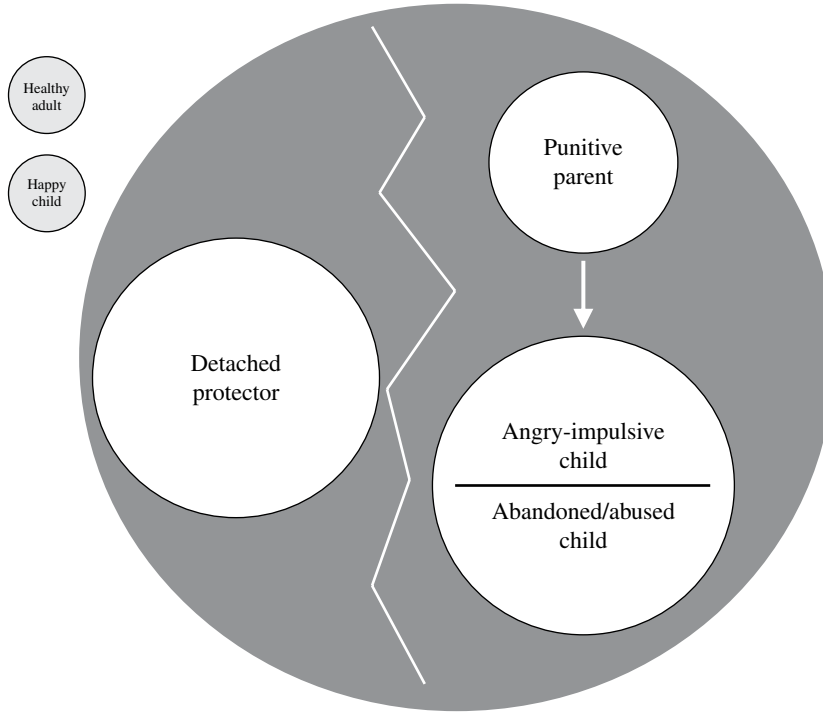

Figure 2.2 Borderline personality disorder: six modes

The detached protector

When the patient is in the detached protector mode, the patient seems relatively mature and calm (See ST step by step 5.08). A therapist could assume the patient is doing well. In fact, the patient uses this protective mode in order to avoid experiencing or revealing her feelings of fear (abandoned/abused child), inferiority (punitive parent), or anger (angry/impulsive child).

The patient also doesn't look happy or relaxed (happy child). Underlying assumptions that play important roles here are those of: it is dangerous to show your feelings and/or desires and to express your opinion. The patient fears losing control of her feelings. She attempts to protect herself from the alleged abuse or abandonment. This becomes particularly evident as she becomes attached to others. The protector keeps other people at a distance either by not engaging in contact or by pushing them away (the detached