Borderline Personality Disorder: Psychotherapy Schema Therapy

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Introduction

In this episode, we have an in-depth discussion about schema therapy, which has proven to be effective in treating borderline personality disorder (BPD), with Australian schema therapist, Andrew Phipps.

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This article is further discussed in the podcast "Psychiatry & Psychotherapy" **Episode 130** found on **iTunes**, **Google Play**, **Stitcher**, **Overcast**, **PlayerFM**, **PodBean**, **TuneIn**, **Podtail**, **Blubrry**, **Podfanatic**

What is schema therapy?

Schema therapy is a model of psychotherapy that was originally designed for chronic mental health problems. It comes from the Cognitive Behavioral Therapy (CBT) tradition, but also integrates different arms of psychotherapy, such as elements from the Gestalt tradition, and also aspects of object relations theory. The founder, Jeffrey Young, was a CBT therapist who became frustrated in his work with people with personality disorders. He found that CBT did not have the outcomes that he wanted, so he integrated the other two arms. There are the ideas of schemas and modes, but really what it comes down to is that we, as the therapists, we are meeting the unmet needs of the client. Schema therapists find ways in the context of the therapist-patient relationship to give the person what they did not get growing up. For example, they may have a need for a sense of acceptance or to feel that they are good enough just the way they are, or a sense of security where they can safely express their needs. The goal is to work towards meeting those needs for the client, and, over time, to teach the client to continue to meet their own needs so they do not need us anymore.

What is the difference between maladaptive schema and transference?

The schema model begins with the idea that there is chronic deprivation of needs during childhood and that this leads to the formation of early maladaptive schemas. Transference is primarily associated with past relationships being projected onto current relationships.

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In a lot of ways they are similar, but one difference is that we assume that schemas are not necessarily just triggered by other people. They can be **triggered by internal stimuli or by things that are happening in the world**; triggers are not only related to interactions with others. We see schemas as having four elements: **cognitive (thoughts/beliefs), emotional, physical sensation, and memory**. In therapy, we try to get the schema brought to the surface so we can go in and meet the need.

For example, if we have a client with a quite distrusting schema from abuse, they are likely going to expect other people in their lives, as well as the therapists, to be a threat to them.

Mistrust/Abuse Schema in BPD

When considering borderline personality disorder, mistrust/abuse is certainly a very common schema for people with this disorder to present with. People with trauma backgrounds also present with this schema. In particular, people who have had physical, emotional, and sexual abuse often present with this schema, in addition to other schemas.

It's not only that the person feels scared, which is the affect attached to mistrust/abuse schema, but they are also likely to feel that people do not care about them and to experience a sense of being alone/sad (which is attached to another schema called emotional deprivation schema). Particularly, people presenting with BPD present with quite a wide range of schemas. Certainly, mistrust/abuse is a really common one for people with that presentation and diagnosis.

Physical Sensation in Schemas

In emotional deprivation schema the common affect is sadness, so it might be a sense of being let down or could be a sense of emptiness. With mistrust/abuse, the main affect is fear. This presents as anxiety, such as your heart beating faster a sense of agitation, pins and needles, pressure on your chest. It could be a whole range depending on the person.

Memories in Schemas

One big difference between schema therapy and CBT is that there is a big focus on making links between developmental events, chronic unmet needs, memories, and the way that we feel in the here and now. So memories, attached to schemas, are a really important part of what therapists are trying to understand. The goal is for the client to be able to link childhood events to the triggering of the here and now.

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Meeting the Unmet Need

The goal of schema therapy is to work towards a way to meet the need in the relationship. If in the therapy the person starts to feel sad or alone, we try to help them feel that we are actually there to support them as long as they need.

But there are a whole range of techniques. A big experiential technique is imagery rescripting. For example, a client talks about an event in the past week where they felt scared and are now feeling scared in the room with us. If they are willing, we might ask them to close their eyes and think of a similar time when they were growing up and felt a similar sort of experience. Then, we come into that event and meet their need by providing what they should have gotten growing up.

We are trying to shift to the idea that we, the therapist, are not that person that created the sense of shame they are experiencing. We do this by validating their emotions ("Of course you feel this way."). Essentially, we are trying to establish that we are not that person [who abused them], we are a completely different person, and this is not a relationship in which they need to feel scared because we are in the here and now.

They begin to realize that the shame, and the intensity of the shame, is not necessarily what is going on between us in terms of their reaction to us and to the present issue. Then, we should become curious about what might be underneath the reaction and, hopefully, move them from a place of feeling bad about having shame to a place of curiosity. If a person becomes angry at us, we could view it as exciting that they were able to experience that anger, which is very counterintuitive to how normal humans interact with anger. It's like anger is an energy to overcome an obstacle. It's often that the person cannot express much anger because, in some abusive situations, anger was pushed down or not allowed or shamed. Their expression of affect or needs may have been repressed or pushed down for years. They may be surprised when it is welcomed and get excited that they are able to express it.

A need can also be anger movement towards a goal. And goals can be needs, such as the need to protect themselves if they have chronic abusive schemas. Having the ability to express anger in a congruent fashion and look at it and not be shamed in the midst of it allows for them to have boundaries in other areas of their life.

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Modes in Schema Therapy

Child Modes

Schema therapy uses the concept of modes. One group of modes are called ‘child modes’. A large focus is on the ‘vulnerable child’ mode. This is the part of us that feels intense distressing emotions such as shame, fear, and sadness. This is the part of the client that we need to access to meet the emotional needs.

Another important child mode is the ‘angry child’ mode. We see the angry child mode as the part of the client, which is expressing unmet needs though anger. E.g., “It’s so unfair… nobody is there for me”. For this reason, we are often very welcoming and encouraging at the expression of anger. It is often through this mode that our clients begin to express their emotional needs. We might say, “It seems like there is a part of you that is really angry. I’m curious to understand this part of you. I really want to hear more of this part of you.” In labelling modes, we often use idiosyncratic terms. In the case of the angry child, we may use a term such as ‘firecracker’.

In therapy with a client with a diagnosis of borderline personality disorder, we may initially focus on anger expression. We see this ‘venting’ of the angry child as imperative to understanding unmet needs. Over time however, we aim to build the ‘healthy adult’ mode, which can express dissatisfaction in a way that others can engage with. For example, we may teach our clients to be assertive in expressing needs without overt aggression or threats.

Coping Mode

At any given time, people are in a mode. They might be in a feeling mode, like a child mode. They might be in healthy adult mode, which is adaptive and quite self-compassionate, attentive to their own needs, as well as aware of the needs of others. But they can also be in a coping mode, which is a set of behaviors that have been necessary to develop as a way to cope with the environments that caused the schema, the environments where the needs were unmet. These coping behaviors also help with coping with the here and now when the schemas get triggered. Some common coping behaviors can be detaching from feelings, dissociation, and shutting off feelings. Developmentally, it was the only way for them to survive. If not, the feelings would be raw all the time.

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A lot of these clients present with a difficulty in getting into contact with their feelings, and may incorporate coping behaviors, such as deliberate self-harm, as a way to regulate their affect, or by using drugs or alcohol as a way to self-soothe. The function of these behaviors, at one time in their lives, has actually not just been functional, but necessary for survival. The difficult thing is that because at one point they've been necessary for survival, it's actually quite scary for them to give them up. So part of the work, in terms of getting through to that part of them that feels the feelings in order to meet the need, is trying to bypass or reduce these coping strategies in the here and now. Initially, we are trying to reduce the coping strategies in the therapy itself.

Healthy Adult Mode (schema therapy) and Wise Mind (DBT)

Healthy adult mode in schema therapy and "wise mind" in DBT are similar concepts. They both involve self-compassion, intuitive thinking, living mindfully, and the balanced combination of the rational mind and emotional mind.

We see this mode as underdeveloped in people with more long-term characterological problems, like BPD, for example, but also things like chronic depression. Because the adult part of them is underdeveloped, the idea in schema therapy is to model that healthy adult for them and meet their needs. Wise mind and healthy adult mode are very similar concepts in the terms of the capacity to both be looking into the world and using evidence, but also being mindful that we are just the way that we are and we feel the way that we feel, and they are both very valid. It's not just about trying to convince them that the way they feel is wrong and that we should be a different way, it's about accepting that we all have a vulnerable part of us. This 'vulnerable child' part has been hurt and feels these feelings for a reason. As 'healthy adults' we need to continue to nurture this vulnerable part of us. To do this we need to recognise that we must form relationships and lifestyles that allow us to continue to have our emotional needs met.

Dysregulation

If someone in our therapy room is distressed, dysregulated, or scared, we need to meet that need and create a sense of safety, which would also include bringing down affect. It might be a few simple steps, like taking deep breaths and just reminding them that this is a safe place. ("I'm here, you're here, if you really want to leave at any time the door is over there and you can leave.") It's imperative to meet that need for the person and to create a sense of safety and agency, as well, so they know they are not stuck or in a position where they do not have any power. We are trying to meet that need and build the part of them that can actually distinguish between what is happening in the here and now and what happened to them growing up. We see that as the healthy adult mode. Before we do that, we have to meet the need and the person has to

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have a felt sense of safety in order to be able to develop this other part of them that can meet the need for themselves. We have this concept called "limited reparenting", and that is essentially what we are trying to do throughout the therapy.

Limited Reparenting

Limited reparenting is the idea that, within the appropriate boundaries of the therapeutic relationship, we are meeting the needs of that person that were unmet growing up. Again, it can be safety, security. Franz Alexander coined the term, "corrective emotional experience", which is a term schema therapy uses. All of the methods in schema therapy are a way of providing a corrective emotional experience.

We can see it in terms of a continuum between care and limits. Most clients that are presenting to therapy, specifically clients with diagnosis of BPD, require more of the care. It might be about a sense of acceptance, a sense of safety, a sense of being listened to, or nurturing, but it could also be that they need more direction and guidance. A lot of clients have missed out on having a strong person to encourage them to do things that are actually difficult and challenging. It is not all about warm fuzzy feelings. A lot of clients present with other types of Cluster B diagnoses: narcissistic personality disorder, antisocial personality disorder. People with these diagnoses do need care and guidance, but often what they need is firm limits. They've often not had someone in their life who is strong enough to let them know that their behavior now is not okay.

Empathic Confrontation

Empathic confrontation can be described as empathy plus limits. It involves being empathic towards the undesirable behavior and understanding that, of course, there is a reason they have developed these behaviors and that the behaviors were probably very adaptive and functional at one time in their life, but also confronting them on the damaging nature of these behaviors now.

Here's a hypothetical example of empathic confrontation: "While I know you are coming here and you're scared, I know that there is a part of you that is worried about me and is worried that I'm going to hurt you, as well, or I'm going to leave you, or I don't care about you. I really want to look after that part of you, and so you need to know that this aggressive and threatening behavior is not good for us or our relationship. When you do that, there is a part of me that finds it hard to connect with you. To be honest, there's a part of me that just wants to bail or leave and I don't want that, I want to be able to stick with the vulnerable part of you that needs care."

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Imagery rescripting

Imagery rescripting can harness a whole range of different techniques and steps. Perhaps one of the most common ones that we start with is what we call a "float back imagery". Some people call it an "affect bridge". The first thing that we are trying to do is attune to a feeling or an event in the here and now. We ask the person to close their eyes and get an image of having that argument with their partner the other day. As they're looking at us and they have that look of disgust on their face, we ask, "How do you feel?" We get a sense of how they're feeling. They could say, "I feel bad/I feel shame." We tell them to hang on to that sense of shame.

So we are imagining an event in the here and now, attuning to the schema, and making a link. We can get them to let go of this image in the here and now, where they're feeling shame and feeling like they have done something wrong. Maybe they have a pit in their stomach, and we ask them to allow themselves to think of a time when they were much younger and had a similar sort of experience; we are making that link and asking the client to recreate the image. We are giving them permission to be that little kid, saying, "You're there...what do you see as you look around? What's going on? Who's there? What are they saying?" Once we have a sense of what that young person needs, **we ask them to bring us into the image**. We say, "Bring me into that image. Would that be okay? Can you see me there?" Once we are there, we are actually meeting the need. We are providing a sense of safety, perhaps protecting that young person from a perpetrator, meeting that need of acceptance, while letting them know they are great the way they are. As the adult, we are portrayed as the way we are in the here and now, and the client is taking the perspective of the child. We ask them to be the child, close their eyes, be that little 8-year-old person, feel the way they feel, and then we come in as an adult.

For example, if a person is reliving a trauma event, we would come in and provide protection and safety. Before the event occurs, hopefully we are coming in and doing whatever is needed to create that sense of safety. We say, "Bring me into the image and I want you to see me standing in between you and your perpetrator. What is it like to know that I'm now there for you, and I'm not going to let them hurt you. How are you feeling right now?" Obviously, our presence sometimes is not enough, so they might say, "I still feel scared because he's so big." So we're using fantasy as well, perhaps saying, "Can you make me bigger so that now I'm towering over on top of them and I'm saying to them, 'You are never going to hurt little Tanya again.'?" We can create many different scenarios, like bringing in Child Protective Services and then asking, "What does it feel like to have all these people protecting you now?" The way that we do it is not as important as actually meeting the need.

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Every time we bring a memory to our mind, the memory changes. So if we insert ourselves into that memory, it will change. Traditionally, it is done by bringing the empathy into that memory and bringing a sense of empathy and compassion together with the person in the here and now. This seems to change the memory, as well.

For example, before the memory work, a client is dreaming of a tsunami coming over them, and then after doing this type of work, in the dream the tsunami will be coming over them but the therapist will be there to protect them and create a bubble around them to bring them out.

In the imagery rescripting model the memories don't necessarily change, but the emotions attached to them and the meaning attached to them change. It's a beautiful process.

Another example would be a client blaming themselves for a traumatic event they experienced. As the therapist, we can come in and, as part of the rescripting, put the blame fair and square on the deserving person or party. Often after this they will experience, for the first time, the realization that they actually aren't actually evil. The potential for transformation is incredible. We have this technique and capacity to, in our language, provide a corrective emotional experience.

Timing is important, but this type of therapy can usually be done quite early on. We need to create a sense of trust and consistency in order for the person to make themselves vulnerable in that way.

Early on in imaging rescripting we, the therapist, are coming in and meeting the need. Over time, as the therapy progresses, we change it. We start off with the childhood image and then we ask the client to shift perspective and to come in as a healthy adult. The two of us are there and we're looking at little James. We ask, "Do you have a sense of what little James needs? Would you like me to look after him or do you want to have a go and care for him?" So within the idea of teaching the client to meet their own emotional needs, we might do that for a while. After some time, what we are doing is asking the client to come in by themselves as an adult and to meet their own needs. It is the progression from the therapist being the healthy adult and meeting their needs, to the client being their own healthy adult and being able to care for themselves and meet their own needs over time. There are other versions of imagery that can be used in the here and now, as well. But imagery rescripting based on childhood events and memories are the most common.

A summary of imagery rescripting would be to imagine an event in the here and now, attune to the feelings, make a link, recreate the event, we come into the image, and then we meet the need.

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Conclusion

Schema therapy is an effective option for Borderline Personality Disorder in which the therapist provides a corrective emotional experience for the client and then as time goes on teaches the client to meet their own needs.

In a future episode we will go through all the different therapies for Borderline Personality Disorder.

Further reading:

Arnoud Arntz, Snežana Stupar-Rutenfrans, Josephine Bloo, Richard van Dyck, Philip Spinhoven, Prediction of treatment discontinuation and recovery from Borderline Personality Disorder: Results from an RCT comparing Schema Therapy and Transference Focused Psychotherapy, Behaviour Research and Therapy, Volume 74, 2015, Pages 60-71, ISSN 0005-7967, https://doi.org/10.1016/j.brat.2015.09.002

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