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Efficacy of Schema Therapy for the Treatment of Borderline Personality Features

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The present study aimed to explore the efficacy of schema therapy for young adults with features of borderline personality. It was hypothesized that features of borderline personality of participants would significantly reduce in posttest followed by schema therapy sessions. The participants of this study comprised of 9 young adult female (Age *M*=23.44; *SD*=2.12) from Karachi, Pakistan who were approached through a purposive convenient sampling technique. In a pre-post experimental design the participants were selected after their screening with the help of Borderline Symptom List-95 (BSL-95; Bohus et al., 2007). Twelve individual schema therapy-based sessions (adaptation of *The Schema Therapy: Clinician's Guide* [Farrell, Reiss & Shaw, 2014]) were conducted. Features of borderline personality of the participants were once again assessed in posttest with the same tool. The statistical analysis of pretest and posttest scores showed a significant decrease in features of borderline personality of the participants. Therefore, the results of the study put forth schema therapy as a promising therapeutic modality for enhancing mental health of individuals with borderline personality features.

Keywords: Schema therapy, treatment modality, features of borderline personality, pre-post experimental design

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According to a systematic literature review, prevalence estimates of personality disorders in Europe ranged between 40% and 92% and were estimated between 45% and 51% in the USA. The estimate for Pakistan was 60% (Beckwith, Moran, & Reilly, 2014). The figures reveal alarmingly high rates of personality disorders in different parts of the world. These figures warrant the immediate need of developing more effective treatment approaches for personality disorders. However, particularly in Pakistan, there is a weak database on the prevalence of personality disorders and their features. Similarly, researches on prevalence of borderline personality disorder and its features in Pakistan can be scarcely found which results in limited research on treatment of this disorder and features. Karim et al., (2004) have also emphasized on the hurdle of limited mental health services in Pakistan. Therefore, in the current study, the researchers attempted to address the void of limited mental health treatment procedures by putting forth a therapeutic modality for features of borderline personality in indigenous context.

The current study focuses on the borderline personality features of unstable self-perception, affect regulation difficulties, self-destructive behavior, feelings of dysphoria and loneliness, negative intrusive thoughts, and hostile attitude. Bohus et al., (2007) also selected these features while developing the first self-report scale to quantitatively evaluate subjective complaints of people with borderline personality disorder. The presence of these features in young adults can also be found in the literature (Hameed, Kumar, Bai, Shaheen, & Athwani, 2017; Saleem, Tufail, Khan, & Ismail, 2015; Shahid & Hyder, 2008).

According to the systematic review conducted by Shahid and Hyder (2008), among other factors, deliberate self-harm has also increased in Pakistan, and the most reported cause for this outcome was interpersonal conflict in recent years. The review further revealed the age of less than 35 years to be a risk factor for deliberate self-harm. A study conducted at a tertiary care hospital in Karachi revealed impulsivity to be most common in the age group of 21 to 30 years of patients (Hameed et al., 2017). Also,

many Pakistani young medical students reported negative experiences in childhood along with current impulsive behavior and inadequate functional identity (Sheikh, Naveed, Waqas, & Jaura, 2018). Another study conducted on South-Punjab undergraduate students stated that 51% of entire sample of students reported little loneliness, 35.5% reported moderate loneliness and 13.5% reported high level of loneliness (Saleem, et al., 2015).

The above-mentioned researches highlight the presence of borderline personality features especially, unstable self-perception, self-destructive behavior, loneliness and hostile attitude. These researches also emphasize the presence of adverse childhood experiences and mark young adulthood as the prime phase for manifestation of these features. Literature database further provides evidence for the borderline personality feature of emotion dysregulation to have a significantly positive relationship with impulsive behavior (Schreiber, Grant, & Odlaug, 2012).

Despite limited empirical evidence on prevalence rates, different psychotherapeutic approaches have been used to treat borderline personality disorder and its features in Pakistani clinical setting. Schema therapy is a form of psychotherapy which is known to be effective for borderline personality disorder treatment worldwide. It has derived its theories and techniques from cognitive behavioral therapy, gestalt therapy, interpersonal psychotherapy, attachment theory and psychodynamic therapy (van Vreeswijk, Broersen, & Schurink, 2014). Schema therapy was initially developed by Dr. Jeffrey Young (Young, Klosko, & Weishaar, 2003).

The Schema Therapy model (Young, Klosko, & Weishaar, 2003) stated that maladaptive schemas are developed when basic emotional needs are not completely fulfilled in childhood. Schemas consist of cognitions, feelings, physiological sensations, and memories experienced in childhood. These schemas are expanded on throughout the lifetime. Maladaptive schemas are psychological structures which comprise of beliefs we hold about

ourselves, other people, and the world (van Vreeswijk, Broersen, & Schurink, 2014). These schemas mostly play an adaptive role for children. By adulthood, maladaptive schemas are erroneous and dysfunctional but firmly held and often out of one's conscious awareness. When maladaptive schemas are stimulated, intense states called modes occur. Dysfunctional modes (comprising of innate child modes, dysfunctional parent modes & maladaptive coping modes) mostly occur when a cluster of maladaptive schemas are triggered together. All modes fulfill the objective of protecting an individual from experiencing fear, anxiety, or pain (Farrell, Reiss, & Shaw, 2014).

The application of schema therapy has been illustrated for cluster C personality disorders in comparison to treatment-as-usual (Bamelis, Evers, Spinhoven, & Arntz, 2014) and borderline personality disorder (Jacob & Arntz, 2013; Nadort et al., 2009; Nysæter & Nordahl, 2008). What is noteworthy is the prominent outcome of relatively large effect sizes. Clinically significant outcomes have been found for schema therapy in researches with different client groups (Masley, Gillanders, Simpson, & Taylor, 2012).

In a Pakistani study, the application of cognitive behavioral therapy focused on schema constructs was revealed to be an effective intervention for dependent personality disorder (Masroor & Gul, 2012). Regarding other psychopathologies, it has been shown that false schemas lead to depression and, application of cognitive therapy and cognitive theories could be helpful in maintaining better mental health (Manzoor, Sial, Manzoor, & Haq, 2012).

The statistics mentioned earlier highlight the occurrence of borderline personality features among young adults and call for immediate measures. Moreover, in the current study, the researchers aimed to highlight the importance of early intervention and the serious need of spreading awareness to family members of people with borderline personality features to take action for safeguarding their mental health. The therapeutic plan was kept brief to entail the impulsive nature of people with borderline

personality features. Thus, it attempted to increase the chances of treatment adherence and completion.

Furthermore, there is a lack of studies for treating people with personality disorder features through schema therapy in the literature database of Pakistan. It shows a gap in the literature and poses a greater need to utilize internationally applied and widely researched effective therapeutic approaches for treating individuals with borderline personality features in Pakistan. The present study intended to provide mental health practitioners in Pakistan with a framework and cross-cultural evidence for the efficacy of schema therapy for treating clients who exhibit borderline personality features.

The purpose of the current study was to establish an empirical evidence for the application of schema therapy with young adults having borderline personality features. Therefore, it was hypothesized that borderline personality features of the participants would reduce significantly after receiving the intervention of schema therapy.

Method

Research Design

The current research is based on a quantitative pre-post experimental design technique; the pre-test was followed by the intervention and the posttest. These scores of pre and posttest were compared to check the efficacy of the therapy.

Participants

The participants of this study comprised of 9 young female adults. All the participants were residents of Karachi, Pakistan and were unmarried. Their age ranged from 22 to 28 years (M=23.44; SD=2.12). All of them were enrolled in undergraduate or postgraduate degree programs while two of them were working as well. The participants were selected through purposive convenient sampling technique.

The sample included those participants who scored a percentile rank between 20 to 60 on the Borderline Symptom List-95 (BSL-95; Bohus et al., 2007) and those who had not taken psychotherapy in the prior 6 months. The selected participants did not have any pre-diagnosed psychological disorder. The participants had at least 12 years of education and they were able to understand, read and speak Urdu and English. The participants with pre-diagnosed psychosis, bipolar disorder, intellectual disability or severe cognitive deficits, and participants reporting unavailability for regular sessions were excluded from the study.

Measures

Following measures were included in the current study

Informed Consent Form

Participants' consent to participate in the study was taken through the informed consent form. The form contained introduction to the research and number and duration of sessions. Their rights to confidentiality and withdrawal from the study were also mentioned. They were asked to sign the form to express their willingness for participation.

Demographic Information Form

Participants' basic demographics were inquired in the demographic information form. Confidentiality for this information was ensured. They were asked to fill in their name, age, gender, birth-order, qualification, work experience, and medical and psychological conditions (if any).

Borderline Symptom List-95 (BSL-95)

It is a self-report questionnaire which consists of 95 items. It uses a 5-point Likert scale; 0=not at all to 4=very strong. It comprises of seven subscales; self-perception, affect regulation, self-destruction, dysphoria, loneliness, intrusion and hostility. The psychometric properties of the scale reveal very high internal consistency for all the subscales and .97 for the total score. The

test-retest reliability for total scale is .84 and ranged betweeen .72 to .87 for the subscales with an exception of hostility subscale. The discriminant validity with other measures of anxiety and aggression is low being <.50 and the scale further yielded statistically significant correlations for convergent validity among all subscales and total score (Bohus et al., 2007).

Procedure

The therapeutic plan for the current research has been developed by adapting the guide, The Schema Therapy: Clinician's Guide, given by Farrell, Reiss and Shaw (2014). Therefore, firstly permission from the authors were sought to apply and adapt the guide. Afterwards, permission from a clinic located in Karachi, was sought to conduct sessions of research participants in the clinic. In the first stage, the prospect participants for the research were invited to participate through social media forums. The registered participants were screened out by applying BSL-95 (Bohus et al., 2007). Nine participants scoring a percentile rank between 20-60 were selected. They were asked to sign the informed consent and fill the demographic information form with BSL-95. The confidentiality of participants' data and identity was maintained.

In the second stage, the participants were provided with 12 individual therapy sessions of 45 minutes each. All sessions were conducted once a week, the details of the session plan are given in table 1 below. When sessions were completed, the participants were asked to fill BSL-95 (Bohus et al., 2007) once again for posttest. The scores of pretest and posttest were statistically analyzed by using the software, SPSS-22. Descriptive statistics of the data were calculated and paired samples t-test was applied.

Table 1

Therapeutic Plan of 12-Weekly Individual Sessions Based on Schema Therapy

Session No.	Activities	Outcome
1	Participant's history. Psychoeducation regarding schemas.	Basic understanding of the concept of schemas.
2	Psychoeducation about modes. Awareness of dominant schemas and modes. Imagery-based coping strategy.	Familiarity with one's maladaptive schemas and modes. Ability to deal with distress.
3	Case conceptualization. Goal setting. Psychoeducation about borderline personality features.	Understanding of the connection between schema activation and dysfunctional modes. Awareness of borderline personality features.
4	Psychoeducation about thoughts, feelings, physiological sensations, behaviors and dominant coping mode.	Familiarity with four components of the record sheet and its application in daily life. Familiarity with one's maladaptive coping mode.
5	Accessing healthy adult mode to deal with maladaptive coping mode by utilizing the record sheet.	Generation of good parent point of view to stabilize self-perception and enhance affect regulation.
6	Awareness regarding dysfunctional parent modes of punitive and demanding parents. Identification of cognitive distortions based on dysfunctional parent modes.	Understanding of the role of dysfunctional parent modes in maintenance of borderline personality features of self-destruction and intrusions.
7	Accessing healthy adult mode to deal with punitive and demanding parent modes. Awareness of vulnerable child mode.	Confrontation of dysfunctional parent modes. Understanding of how vulnerable child mode sustains borderline personality features of dysphoria and loneliness.
8	Accessing healthy adult mode to deal with vulnerable child mode. Awareness regarding angry and impulsive child modes.	Enhancing good parent point of view to address needs of vulnerable child mode. Understanding of the underlying reasons which activate angry and impulsive child modes. Also, how these modes are linked with borderline personality feature of hostility.
9	Deeper understanding of maladaptive coping modes, dysfunctional parent	Enhancing healthy adult mode to deal with all these modes in an

	modes and innate child modes through experiential mode-work. Psychoeducation regarding mode-flipping.	effective manner. Understanding of the mechanism of affect dysregulation.
10	Understanding and accessing happy child mode. Positive feedback from healthy adult mode to happy child mode.	Further enhancing subjective wellbeing.
11	Understanding healthy adult mode at a deeper level. Exploration of future healthy adult mode.	Ability to access healthy adult mode in both, immediate and distant future.
12	Brief review of all the relevant techniques. Discussion on thoughts and feelings related to therapy termination.	Prevention of relapse of borderline personality features-based symptoms in future. Emotional closure regarding the therapeutic process.

The above mentioned table shows the detailed 12-weeks session plan of schema therapy. Activities that have been scheduled for each session with plausible outcomes are discussed.

Results

The data was analyzed on SPSS-22. Descriptive statistics of the data were calculated and paired samples t-test was applied.

Table 2

Descriptive Statistics for Features of Borderline Personality Before & After Intervention (N=9)

FBP	*M*	*SD*	*SK*	*K*	*Min*	*Max*
Pretest	173.22	24.56	-.304	-.599	130	204
Posttest	89.89	67.28	.656	-.347	15	215

Note. FBP=Features of Borderline Personality

Table 1 shows mean, standard deviation, skewness, kurtosis, minimum and maximum values which show that data is normally distributed.

Table 3
Paired Samples t-test for the Comparison of Features of Borderline Personality Before & After Intervention (N=9)

	Pretest		Posttest					95% CI		*g*
Variable	*M*	*SD*	*M*	*SD*	*MD*	*t*	*p*	*LL*	*UL*	
FBP	173.22	24.56	89.89	67.28	83.33	2.98	.01	19.01	147.65	1.64

Note. FBP=Features of Borderline Personality

Table 3 shows mean difference and result of paired samples t-test. The results exhibit significant decrease in borderline personality features of participants in the posttest.

Discussion

The objective of the current study was to explore the efficacy of schema therapy to alleviate borderline personality features in young adults. Therefore, it was hypothesized in the current study that features of borderline personality would reduce significantly after receiving the intervention of schema therapy. The results of the study have supported this hypothesis and showed a significant reduction in participants' borderline personality features in the posttest. Hence, keeping in focus the range of published literature, results of the hypothesis of current study are in congruence with the results of previous studies.

A consecutive case series study with 6 borderline personality disorder outpatients is an instance of previous studies highlighting effectiveness of schema therapy. Individual schema therapy was provided to outpatients between 1.5 and 3 years once per week (varying as per patient's needs). Within-schema therapy meta-analyses were done by using average pre and post within group effect size. No dropout was reported and 50% of the patients did not meet the borderline diagnosis at the 12 months follow-up (Nordahl & Nysaeter, 2005).

Schema therapy was initially developed to work with patients who had severe psychological problems and who failed to achieve substantial gains through cognitive therapy. Although schema therapy has been used very frequently with personality disorders, other clinical disorders could be an important application too. Schema therapy has been applied to treat patients with eating disorders. A 20–session based research was conducted in which 8 patients who had chronic eating disorder with high comorbidity level participated. Reductions between pre and post-tests were found among group completers for the levels of global schema severity, anxiety, shame and eating disorder severity. Large effect size was found at follow-up. 4 out of 6 group completers showed clinically significant improvement in eating severity (Simpson, Morrow, van Vreeswijk, & Reid, 2010).

In the current study, following therapeutic aspects were analyzed during schema therapy sessions which may have stimulated change in borderline personality features of participants. In the beginning of the therapeutic process, the participants were facilitated to become aware of their dominant maladaptive schemas, relevant childhood memories, how these schemas could have developed and how they usually activate their dysfunctional dominant modes. The psychoeducation phase per se seemed to have brought about a healthy change in participants to some extent. They started observing the real-life manifestation of their maladaptive schemas. Through record keeping technique, they began to identify triggering situations which activate maladaptive schemas. All this led to a little sense of empowerment and an insight in participants that they possess the ability of repeating and breaking the pattern of their schema-mode activation.

The participants also identified their dominant maladaptive coping mode (out of compliant surrendered, detached protector & over compensator). They observed how their identity seemed unstable to them at times as they avoided or denied feelings, or how they sometimes withdrew and gave away charge of life to other people and circumstances, or how they tried to fight against

their schemas to prove otherwise to themselves and others. The understanding and recognition of thoughts, feelings, physiological sensations and mode-specific unhealthy behaviors catalysed the awareness process and identification of triggering factors. They also made a verbal agreement in the session to lower the intensity of these unhealthy modes and to give more control to healthy modes. Due to both these techniques, participants' self-perception somewhat improved, they felt autonomous and initiated catching themselves whenever they were trapped in the cycle of unhealthy coping modes.

Moreover, dysfunctional parent modes (comprising of punitive & demanding parent modes) appeared to be a source of negative intrusive thoughts and self-destructive behavior in participants. They expressed many instances of having repetitive thoughts of self-doubt. These thoughts appeared to have reduced their self-image which was keeping them from taking initiatives in studies and workplace. They experienced ruminative guilt and self-loathing. The participants showed inclination towards fulfilling parent modes' dictate that they deserved punishment or they were a failure. The parent modes also seemed to be a source of reducing hope in some of the participants as their judgment condemned the participant and generated feelings of worthlessness. The exploration of dictates or beliefs and unrealistic expectations of dysfunctional parent modes helped participants to confront their negative intrusions and self-doubt. They were able to acknowledge their achievements and inner potential in a more realistic manner.

Other than dysfunctional parent modes, the participants exhibited some of the dysfunctional child modes as their dominant modes. For example, they exhibited vulnerable child mode by reflecting abandonment fear, dysphoric mood, and feeling of being alone, helpless and vulnerable. They reported intense anger and hostile feelings, which is the manifestation of angry child and impulsive child modes. For some of them, the impulsive child mode fuelled action that was potentially damaging for themselves and others. During schema therapy sessions, participants were able to explore their current fears, need for attention, childhood needs

and whether these needs still long for gratification. They generated a healthy way of fulfilling their needs and asking for attention by empowering their healthy adult mode. They also tried to accept their fears and anxieties and attempted to allow more expression to their happy child mode by integrating fun activities in daily life. Awareness of mode-flipping further provided participants with insight into their affect regulation difficulty and unstable relationships.

In a nutshell, the intervention plan presented in the current study facilitated participants to fulfil their unmet childhood needs with the help of schema therapy interventions of psycho-education and awareness of schemas, modes and mode-flipping along with cognitive, experiential and behavioral techniques. Mode language focused more on the role of learning and giving participants hope regarding change. This is how schema therapy helped activate healthy and functional modes; the healthy adult mode and happy child mode, and participants were eventually less driven by their maladaptive schemas.

What is noteworthy here is that schema therapy sessions were able to facilitate participants in decreasing their borderline personality features to a significant extent. Thus, the present study aims to provide mental health practitioners in Pakistan with an evidence-based therapeutic plan which can be utilized for enhancing mental health of clients who exhibit borderline personality features.

Conclusion

The research article presents relevant literature along with application and outcome of schema therapy in individual sessions to reduce borderline personality features of young adults. The literature showed that schema therapy has been effective in decreasing psychopathological symptoms among individuals with personality disorders and other few clinical disorders but its effects for individuals with borderline personality features have mostly been unexplored. Therefore, the present study focused on the

segment of those individuals whose symptoms are mostly not given enough and timely attention by family members and even clinicians. Moreover, the therapeutic plan implemented in the study is brief and thus more client-oriented as it demands less time and cost in contrast to usual schema therapy-based plans. In the light of outcomes of the current study, it can be concluded that schema therapy can be an effective medium for alleviating borderline personality features of young adults.

Limitations of the study and recommendations for future research

The current study included a limited sample size which can be increased for future researches on schema therapy. Moreover, the present study comprised of female participants only. A larger sample size based on both female and male participants in future can be more methodologically rigorous and would allow better generalizability of results on the efficacy of schema therapy for borderline personality features.

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