Schema Therapy for Borderline Personality Disorder

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This article presents the Schema Therapy (Young, Klosko, & Weishaar, 2003) approach to the treatment of borderline personality disorder. Schema therapy draws on the cognitive-behavioral, attachment, psychodynamic, and emotion-focused traditions and conceptualizes patients who have borderline personality disorder as being under the sway of five modes or aspects of the self. The goal of the therapy is to reorganize this inner structure. To this end, there are four core mechanisms of change that are used in this therapy: (1) limited reparenting, (2) experiential imagery and dialogue work, (3) cognitive restructuring and education, and (4) behavioral pattern breaking. These interventions are used during the three phases of treatment: (1) bonding and emotional regulation, (2) schema mode change, and (3) development of autonomy. © 2006 Wiley Periodicals, Inc. J Clin Psychol 62: 445–458, 2006.

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Introduction

Borderline personality disorder (BPD) has traditionally been seen as one of the most difficult psychiatric disorders to treat through psychotherapy. Schema therapy (Young & Klosko, 1993; Young et al., 2003), which has been evolving as a treatment over the past 20 years, is presented here as a new and promising approach for the treatment of those suffering with this disorder.

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Schema Therapy: Origins

The schema therapy approach to borderline personality disorder (BPD) is, in a way, filled with irony. Jeffrey Young, who worked with Aaron Beck in Philadelphia (Young, Beck, & Weinberger, 1993), was interested in the nonresponders to, and relapsers from, cognitive therapy. The study of these treatment "failures" led to an understanding that they frequently had much more rigid cognitive structures; more chronic, often lifelong psychological problems; and more deeply entrenched, dysfunctional belief systems. These "schemas" were typically found to be rooted in a troubled or abusive childhood—a childhood in which the basic needs of the child were not met, and maladaptive coping or survival styles were embraced by the child. Outside the home environment and in adult life, these coping styles and worldviews presented more problems for the patients and for those around them.

These patients, in many cases, fit the definition for having a personality disorder. The *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition (American Psychiatric Association, 1994) describes a personality disorder as "an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment" (p. 629). One of the key aspects of this definition is the emphasis on the rigidity of the disorder.

Treating patients who have personality disorders presented many challenges for the cognitive-behavioral therapist. Young (Young et al., 2003) found that it was necessary to lengthen the time of treatment, to spend much more time exploring the childhood experiences of patients, and to place greater emphasis on the nature and strength of the therapeutic relationship. Efforts to categorize and codify maladaptive childhood themes moved Young's ideas closer to those of some psychodynamic thinkers, particularly object relations and attachment theorists (Ainsworth & Bowlby, 1991; Greenberg & Mitchell, 1983). Finally, as a way of greatly increasing the power of the therapeutic interventions, Young incorporated a range of techniques from the Gestalt and emotion-focused therapies (Greenberg, 1979; Greenberg, Rice, & Elliott, 1993; Greenberg, Safran, & Rice, 1989; Perls, 1969, 1973, 1975), particularly imagery work and empty chair dialogues (Kellogg, 2004), and, to a lesser extent, awareness exercises (Stevens, 1971).

The result was a truly integrative psychotherapy. Early maladaptive schemas could be assessed and identified through the use of questionnaires such as the Young Schema Questionnaire (Young & Brown, 2001) and the Young Parenting Inventory (Young, 1994), through imagery work, through observations of the patient's behavior in the therapy situation, and through patient accounts of their experiences and difficulties. A model of 18 schemas was ultimately developed, and guidelines were developed for the treatment of schemas and coping styles that utilized the full range of cognitive, behavioral, and emotion-focused techniques (Young et al., 2003).

BPD and the Development of Modes

Borderline personality disorder (and, to a lesser degree, narcissistic personality disorder) presented unique challenges to the original schema therapy model. Although most patients who have personality disorders were trapped in a rigid style that was amenable to schema work, BPD patients were not infrequently in a state of flux. It was the rapidity of emotional change, often from adoration to hatred, that was so difficult for therapists, friends, and family members.

Further complicating the situation, many of these patients frequently endorsed the top range of almost every item on the schema inventories, thus overwhelming both the

patient and the therapist. Young's (Young et al., 2003) solution was to understand that these patients were "flipping" through clusters of schemas and coping styles and that it would be much more useful to envision the patient's personality as consisting of various *modes* or different aspects of the self. These different modes are delineated in the following discussion.

The Origins of BPD

BPD is thought to have a three-factor origin: (1) genetics and temperament, (2) childhood experiences in the family and in the outside world, and (3) the interaction between the child's temperament and the parenting style and reactions of the caregivers. The proposed genetic and temperamental origins are centered on a proclivity for "an emotionally intense, labile temperament" (Young et al., 2003, p. 311).

The family environmental situations (Young et al., 2003, p. 312) that may contribute to the development of the disorder are the following:

1. The family environment is unsafe and unstable.

2. The family environment is depriving.

3. The family environment is harshly punitive and rejecting.

4. The family environment is subjugating.

These four criteria are what would be expected to be found in a family situation characterized by neglect and abuse, and a significant number of BPD patients report experiences of sexual, physical, and/or emotional abuse (Lobbestael, Arntz, & Sieswerda, 2005).

Abuse, although common, is not always a contributing factor. In these cases, a "mismatch" between the child's temperament and the parents' child rearing style may be a significant factor. The emotional intensity of these children may not mesh with approaches taken by parents who are excessively rigid or authoritarian or are unable to deal with affect. The resulting patterns of anger, frustration, or disconnection may further exacerbate the difficulties of these children.

Borderline Modes

Young (Young et al., 2003) sees BPD as a disturbance that is on a continuum with multiple personality or dissociative identity disorder. Fundamentally, the inner world of the borderline patient is characterized by five modes, or aspects of self, that interact in destructive ways. In this interaction the patient is living in a kind of inner theater in which the forces of cruelty, rage, submission, and self-numbing each take their turn on the stage. Strikingly, an understanding of the interplay of these modes also helps to explain the apparently "irrational" behavior of these patients.

There are, in essence, three groups of modes—child, parent, and coping modes. Although the mode concept is now seen as the essence of schema therapy work with severe personality disorders—such as borderline, narcissistic, and antisocial disorders—not all of these modes have equal weight in each disorder. (For a fuller discussion of the mode model, see Young et al., 2003.)

There are five central modes in the borderline constellation: (1) the abandoned and abused child, (2) the angry and impulsive child, (3) the detached protector, (4) the punitive parent, and (5) the healthy adult modes (Young et al., 2003). The development of the

healthy adult is one of the goals of the therapy, and it is typically first embodied in the therapist and then, through the therapy process, internalized by the patient.

The Abandoned/Abused Child Mode

The abandoned/abused child embodies the theme of frightened isolation. In this mode,

> patients appear fragile and childlike. They seem sorrowful, frantic, frightened, unloved, lost. They feel helpless and utterly alone and are obsessed with finding a parenting figure who will take care of them. (Young et al., 2003, p. 308)

This is a core state of being for the borderline patient, and it underscores one of the key philosophical points of this kind of treatment—that the therapist should envision these patients as functioning as young children at a core emotional level.

The Angry and Impulsive Child Mode

The angry and impulsive child mode reflects the part of the child who knows that she did not have her needs met—who knows that she suffered unfairly. "The Angry Child mode expresses rage about the mistreatment and unmet emotional needs that originally formed her schemas—the abuse, abandonment, deprivation, subjugation, rejection, and punishment" (Young et al., 2003, p. 348). The angry and impulsive child is another one of the paradoxes of the borderline patient's predicament. In a sense, the patients are right to be angry. This mode can be activated in situations in which there are real or perceived occasions of deprivation, mistreatment, or abandonment. The rage that erupts is frequently deeply troubling to family, friends, and therapists; it is typically seen as one of the most difficult aspects of treating BPD patients. The tragic aspect is that this rage makes it even less likely that their needs will be met.

The further dilemma is that in the childhood situation of many of these patients, expressions of emotions, especially anger, and desires were forbidden. After these angry outbursts, the punitive parent may become activated and punish the abandoned/abused child. These kinds of displays of rage may then be followed by cutting or other forms of self-punishment as the patients replay the dynamics of their family situation.

In the therapy context, the patient is under the sway of the detached protector mode, a coping mode in which the patient "shuts down" and becomes relatively compliant and nonresponsive. Nonetheless, the patient's level of frustration is building and, if his or her feelings are not expressed and their needs are not eventually met, the angry and impulsive child erupts.

The Detached Protector Mode

Despite the reputation that patients who have BPD have for dramatic displays of "acting out" behavior and high levels of emotional intensity, most of the time, they are typically functioning in what is called the *detached protector mode*, in which the patient adopts a "style of emotional withdrawal, disconnection, isolation, and behavioral avoidance" (Young et al., 2003, p. 275).

> In the detached protector mode, patients may feel numb or empty. They may adopt a cynical or aloof stance to avoid investing emotionally in people or activities. Behavioral examples include social withdrawal, excessive self-reliance, addictive self-soothing, fantasizing, compulsive distraction, and stimulation seeking (p. 275).

Another complication here is that although the detached protector mode has helped patients survive, it interferes with psychotherapeutic progress and keeps the abandoned and abused child blocked off from a therapeutic connection.

The Punitive Parent Mode

"The punitive parent is the patient's identification with and internalization of the parent (and others) who devalued and rejected the patient in childhood" (Young et al., 2003, p. 341). Not only did the patient often grow up with an abusive parental figure, but the internalization of the object means that that inner abuse continues. The punitive parent is an extremely harsh part of the self that punishes the patient for being "bad," and "badness" is a pervasive concept that can include almost any aspect of the patient's existence (Young et al., 2003). BPD patients, when under the control of this mode, frequently describe themselves as "evil" and "dirty" and may engage in parasuicidal behaviors such as cutting or mutilating themselves.

The therapist works to help patients recognize this part of themselves as a mode and to give this aspect of the personality a descriptive name (such as "your Punishing Father"). The naming of the mode helps the patient gain some distance from this aspect of herself. BPD patients eventually learn to question the harsh messages and to fight back against the cruelty. This mode is seen as having no adaptive value, as it is rooted in the abuse, not the affirmation, of the child.

The Healthy Adult Mode

The healthy adult mode is what the BPD patient, for the most part, is missing. This mode "serves an 'executive' function relative to the other modes. The healthy adult helps meet the child's basic emotional needs" (Young et al., 2003, p. 278).

Young and associates (p. 278) state that as a good parent the healthy adult mode serves the following three basic functions:

1. Nurtures, affirms, and protects the vulnerable child.

2. Sets limits for the angry child and the impulsive/undisciplined child, in accord with the principles of reciprocity and self-discipline.

3. Battles or moderates the maladaptive coping and dysfunctional parent modes.

The weakness of this mode in BPD patients is an important contributor to the turbulence in their life. One of the functions of the therapist is to take on the role of the healthy parent (within the limits of a therapy relationship). Schema therapy for BPD is thought to take at least 2 years, because a central goal is for the patients to begin to internalize the therapist as the healthy parent. In this way, patients can eventually do for themselves what the therapist is doing for them in the session.

Mechanisms of Healing and Change

There are four mechanisms of healing and change that are at the core of schema treatment for borderline personality disorder: (1) "limited reparenting," (2) emotion-focused work—specifically imagery and dialogues, (3) cognitive restructuring and education, and (4) behavioral pattern breaking.

Limited Reparenting

Although all four interventions are central in the treatment process, limited reparenting may be "first among equals." At its core is the belief that the patients did not have their core emotional needs met by their parents or caregivers, and in response, the therapist tries to compensate for these deficits, while maintaining appropriate professional boundaries.

In the case of BPD patients, the understanding is that psychologically and emotionally the patients are still very young children. The therapy seeks to create a place in which patients can grow from functioning as children to functioning as healthy adults. To achieve this end, therapists conduct themselves in ways that are warm and sympathetic, and they seek to create a situation that provides "safety, stability, and acceptance" (Young, 2003, p. 330). Especially at the beginning of therapy, there is a greater emphasis on feelings and empathy than on problem solving.

Therapists also reparent through their behaviors. When appropriate, they may self-disclose if they believe that the patient will gain from it. They also provide the patient with their home phone number to be used during crises and give extra session time and have phone sessions or e-mail exchanges, as needed.

For patients who have difficulties related to separation and abandonment (Greenberg & Mitchell, 1983), the therapist may make check-in calls or give patients flash cards or other "transitional objects" during breaks or between sessions (Young, 2000). Reparenting takes place not only in the interactions and dialogues of the therapist and the patient, but also in the emotion-focused, experiential work.

Experiential Techniques

The extensive use of emotion-focused techniques in schema therapy is one of its defining qualities. The three central experiential techniques used in schema therapy are imagery work, dialogues, and letter writing.

In an assessment technique, patients are asked to close their eyes and bring up images and memories of difficult situations with their parents, siblings, other family members, and peers. This process begins to give therapists a sense of the kind of early experiences that patients went through, and the kind of factors may have contributed to their present situation.

In the context of upsetting images and memories from the past, therapists—functioning as the healthy adult mode—can enter into childhood scenes and protect and support the abandoned/abused child. After the therapist has done this, patients take on the healthy adult role by entering into the image, protecting and affirming the child modes. Traumatic memories are dealt with in a similar fashion, but these are approached much more slowly and only with the patient's permission. The therapist and patient process each element of the traumatic experience carefully before they move on to the next.

Another important aspect of schema treatment for BPD patients is the use of dialogues. Therapists and patients frequently have dialogues to affirm and nurture the abandoned/abused child and to fight the punitive parent. These dialogues can be done in imagery, in which patients create visual representations of these different parts of themself, or through Gestalt chair work (Greenberg, 1979; Greenberg et al., 1993; Kellogg, 2004; Perls, 1969, 1973, 1975). Using "empty chair" and two-chair techniques, patients and therapists can have dialogues among the various modes. Using role play, modeling, and coaching, therapists can help patients to develop and strengthen their healthy adult mode. One important goal for BPD patients is to conceptualize the critical "voices" in

their mind as being separate from the core self. The physical nature of chairwork helps with this process because the punitive "voice" can be located outside them.

The third type of experiential technique used in this work is letter writing. Patients can write to those who have harmed them or who have behaved in critical and repressive ways. In these letters, they express their feelings and affirm their needs. These letters are read in the therapy session. However, they are not written with the intention of actually being sent; in fact, patients are cautioned about the consequences of actually sending them.

Cognitive Techniques

Cognitive techniques play an important role in schema therapy. The two primary goals of these techniques are education and cognitive restructuring. The educational aspect is focused on teaching patients about normal needs and normal emotions. The normal needs include being safe, having a "stable base," getting love and nurturing, being accepted and affirmed, being treated empathically, receiving proper guidance and protection, and having one's feelings and needs validated. In the philosophy underlying schema therapy, all children have a right to have these core needs satisfied; problems in development typically occur when they are not met.

Most BPD patients have not had their basic needs met adequately in childhood. Furthermore, they were usually told that expressing these needs, or even having them, was wrong; patients who have BPD were often harshly punished for this behavior. The educational aspects of the therapy validate patients' rights to have these needs met in their relationships—while also teaching patients that they need to negotiate their desires on the basis of respect for, and reciprocity with, others.

The same is true for emotions. Again, many BPD patients do not feel that they have the right to express their emotions, particularly anger. In the detached protector mode, patients shut down all of their emotions as a coping or survival technique.

Validating patients' right to be angry is important. However, the management of its expression is important, and assertiveness training is used to help patients express their feelings and needs appropriately and effectively. Anger that is interpersonally based may be related to dichotomous or "black and white" thinking about the actions of others. In-session cognitive restructuring and between-session flash card use are approaches that can serve to develop a more moderate, complex, nuanced, and reality-based interpretation of the behavior of others (Young & Klosko, 1993; Young et al., 2003).

The healing process is marked by both progress and setbacks. When confronted with failures, patients may be very harsh and blaming toward themselves. The schema therapist teaches patients that punishment is not an effective way to change behavior and that he or she does not subscribe to it. Instead, positive reinforcement and shaping are much better ways of changing one's behavior and one's life.

Related to this, patients may tend to blame themselves for the difficult experiences that they had as children (i.e., if only they had been better children, their parents would have loved them). Cognitive restructuring here is centered on the idea that the parent had problems and difficulties and that is why matters did not work out better. In addition, the good qualities of the patient are emphasized, to help to combat the toxic messages of the punitive parent.

Behavioral Pattern Breaking

The behavioral pattern breaking phase of treatment is typically the last and often the longest. After making internal mode changes, patients are guided in generalizing what

they have learned in the therapy sessions to relationships outside. To do so, the work often "incorporates other schema strategies, such as flash cards, imagery, and dialogues. When relevant, the therapist also uses traditional behavioral techniques, such as relaxation training, assertiveness training, anger management, self-control strategies (i.e., self-monitoring, goal-setting, self-reinforcement) and graduated exposure to feared situations" (Young et al., 2003, pp. 146–147). Therapists and patients can work together to clarify which behaviors are having the most negative impact on their life and the lives of others, and the most serious behaviors can be chosen as targets for change. In many cases, these are interpersonal situations.

Not surprisingly, BPD patients may expect that others will act as punitive parents and will not be responsive to their needs and emotions, even if the patient presents them in an appropriate manner. In vivo exercises can be designed so that the patient can see that these are usually distorted expectations.

Role playing and behavioral rehearsal can be used in the session to develop skills and to anticipate problems. One of the goals is that this new behavior will result in a positive and reinforcing response from others and a new interactive pattern can be developed.

Stages of Treatment

Schema therapy of borderline personality disorder consists of three phases of treatment that include a variety of interventions. The three phases of treatment are (1) bonding and emotional regulation, (2) schema mode change, and (3) development of autonomy. Each of the four mechanisms of change plays primary or secondary roles during these phases of treatment; nonetheless, all are crucial to the success of the therapeutic endeavor.

Bonding and Emotional Regulation

The bonding and emotional regulation phase of treatment is centered on developing a relationship between the therapist and the patient that is a contrast and an antidote to the abusive or punitive one that the patient experienced as a child. The therapy situation becomes a "holding environment" (Winnicott, 1965), a safe place in which the patient is affirmed and the expression of needs, desires, and feelings is encouraged.

The therapist explores current situations and difficulties that the patient is facing. Open-ended questions are used so that patients are invited to speak more openly about their emotions. This encouragement contrasts with the subjugating experiences, in which the child was not allowed to express feelings or desires, that were so common with the punitive parent.

After the exploration of current issues, discussion of childhood and adolescent experiences begins. The Young Parenting Inventory (Young, 1994) is a good stepping-off place for this investigation. Throughout these explorations, the goal is to try to keep the patient in the abandoned/abused child mode. There are several reasons for keeping the patient in this mode.

When the patient has an affirming relational experience while in the abandoned/abused child mode, that experience is therapeutic. The patient is being heard, many of his or her needs are being met in the therapy relationship, and other needs can be met through experiences in imagery. The vulnerability of the patient helps the therapist to develop a deeper bond with the patient, a bond that is essential for the patient and therapist to weather difficult times.

If the patient is in the abandoned/abused child mode, he or she is therefore not in the angry and impulsive child mode. Again, the angry and impulsive child mode, although

justified in many respects, becomes counterproductive when it damages relationships and drives others away. The therapist does encourage the expression of anger, but in a more controlled way that keeps both parties "in relationship." Working to keep the patient in the abandoned/abused child mode helps to stabilize patients as they begin to internalize their experience with the therapist as the healthy parent.

During the first stage, and throughout the therapy, patients and therapists need to negotiate several vital issues. First, as therapists gain access to the abandoned/abused child, they activate all of the patients' needs and longings that have been unmet. As discussed previously, this process allows the therapist to engage in limited reparenting behavior.

The second vital issue is that of self-destructive behavior, which may include such forms of self-harm as cutting, self-mutilation, substance abuse, and suicidality. Specific guidelines for addressing the feelings that precipitate these kinds of behaviors are worked out by the patient and the therapist so that the patient has a plan for self-care. Throughout this first phase, the therapist educates the patient about the five borderline modes and points out "mode flipping" in session.

Schema Mode Change

Mode work involves maintaining a relationship with the abandoned/abused child while working to reorganize the inner mode constellation of the patient. With the abandoned/abused child, the therapist continually seeks to connect with and affirm this part of the patient's personality. The therapist praises patients and calls them "generous, loving, intelligent, sensitive, creative, empathic, passionate, or loyal" (Young et al., 2003, p. 335). Again, these messages contrast with the messages with which patients grew up. Not infrequently, they trigger the punitive parent mode, and patients reject these affirmations or even try to punish themselves later. Nonetheless, the message still resonates with the abandoned/abused child.

The Detached Protector: Treatment Issues

As noted earlier, the detached protector is a survival mechanism developed by the patient during the difficult, traumatic, or abusive situations he or she previously experienced. This mode helped patients by allowing them to shut off their pain and comply with the needs of others. The dilemma in therapy is that this mode prevents the therapist from gaining access to the abandoned/abused child, and that is ultimately the only way to make progress.

There are several steps involved in work with the detached protector. First, the mode is identified as it emerges in the therapeutic encounter. The therapist and the patient explore the benefits and costs involved in allowing this mode to dominate. The therapist also consistently works to protect the abandoned/abused child throughout the process so that the detached protector can have more confidence in the safety of the situation.

Therapists also seek to induce patients to work to get past the detached protector. This process could include bringing up an image that relates to the mode, and then having a dialogue between the therapist and the detached protector about why the therapist needs to make contact with the abandoned/abused child and the steps that are taken to keep the child safe.

If patients do allow the abandoned/abused child to emerge and are flooded with anxiety and painful emotions, the detached protector could be retriggered. One solution is

to titrate the intensity and frequency of affective work carefully. Another is to consider the use of medication to help reduce the intensity of affect.

The Punitive Parent: Treatment Issues

In order to protect the abandoned/abused child, the therapist eventually has to do battle with the punitive parent. This process is achieved in several ways. First, this oppressive and critical voice is labeled as a mode; labeling helps to reduce the level of identification and to give the patient some distance from the punitive parent mode. Early on, therapists ask patients to verbalize the message of the punitive parent, and then they directly challenge what the punitive parent is saying. They identify the needs that the parent did not meet and affirm the patient's right to have those needs met. Repeated dialogues between the punitive parent and the therapist are necessary. In these dialogues the therapist gives voice to what distresses the angry and impulsive child. The purpose is to expunge the voice of the punitive parent, not to integrate it.

The patient, with support from the therapist, will later begin to take on the battle of challenging the punitive parent. This challenging can involve confronting parents in experiential exercises for mistreating them (i.e., "I won't let you talk to me like that"; Young et al., 2003, p. 345). Not only does the angry and impulsive child learn to speak out against the punitive parent in these dialogues, but the patient eventually takes on the role of the healthy parent.

In cases in which there has been abuse, imagery work can be exceptionally valuable in helping patients work through it. The therapeutic work involves keeping patients moving forward while protecting them from being overwhelmed. To this end, patients can move through the abuse scenario piece by piece. Several sessions of exploration can follow one session of imagery. The therapist and the patient can agree on a signal (i.e., raising a hand) if the experience becomes too intense. The patient can go into the image as an adult, along with the therapist, to protect the child. The therapist serves as the good parent by protecting the child, confronting the perpetrator, and creating safety with a wall or shield. This is done repeatedly until patients feel that they can go into the image and protect the abandoned/abused child themselves. The purpose is to move the patient from an experience of victimization to one of safety and empowerment.

The Angry and Impulsive Child: Treatment Issues

As noted, the angry and impulsive child is the embodiment of the patient's rage at the abuse and deprivation. The paradox here is that this rage can be both useful and destructive, and the therapist must be able to work with it in such a way that it can be a source of healing and power.

Once the therapist has convinced the detached protector to move aside, there is a possibility that the angry and impulsive child, rather than the abandoned/abused child, will be activated. As patients begin to experience their pain and deprivation, they typically look to the therapist to fill their needs for love, nurturing, affirmation, and protection, and although the model here is one of reparenting, the therapist is inevitably unable to meet the patient's needs at the level at which he or she wants them to be met. This failure stems from the fact that the therapist is, ultimately, not a true parent. The angry outbursts that ensue are commonly one of the most frustrating aspects of work with BPD patients. In the moments when the angry/impulsive mode is in operation, it is as if all the good work and all the positive connections that went before have been obliterated.

There are three arenas in which the angry and impulsive child can come into play: the therapeutic relationship, the reworking of traumatic experiences through imagery and chair work, and interpersonal relationships outside the session. These can be addressed in different ways.

For in-session anger, especially anger directed at the therapist, the goal is to give the patient two messages simultaneously: "The first is that the therapist wants to hear the patient's anger; the second is that the patient has to express the anger within appropriate limits" (Young et al., 2003, p. 349).

There are four steps involved in processing anger in sessions—whether directed at the therapist or at someone else in the patient's life:

1. *Ventilate*: Here, the patient is encouraged to express the anger as fully as possible and to work to clarify what is at the core of it, so long as the patient is not abusive or destructive. The therapist prompts anger through such statements as "Tell me more about that. Explain why you're angry at me" (Young et al., 2003, p. 350). In what may seem counterintuitive, the therapist will have more success if she or he takes a more neutral, fact-finding tone. This technique is used because empathic reactions tend to diffuse angry responses; the goal is to clarify the wound or schema that is being activated.

2. *Empathize*: Next the therapist responds empathically to the wound that was activated with an acknowledgment of the pain that the therapist's behavior may have caused. Through this acknowledgment, the therapist is trying to move the patient from the angry and impulsive child to the abandoned/abused child, to the actual experiences of deprivation and abuse that were hurtful.

3. *Reality testing*: Psychotherapists should avoid taking a punitive or defensive stance and should acknowledge those aspects of the situation about which the patient was accurate (i.e., they might disclose that they were preoccupied when the session started, or that they were tired). They then go on to point out gently those aspects of the anger that are schema driven and that are distortions of the actual situation. A fundamental message is that therapists are imperfect, but they do care.

4. *Rehearsal of appropriate assertiveness*: After the anger has abated, therapists help patients explore how they could have expressed their needs in an assertive rather than an angry manner. "The therapist asks the patient, 'If you could do it over again, how would you express your anger to me? How could you express what you need and feel in a way that I, or other people, can listen and not become defensive?'" (Young et al., 2003, p. 351).

Ultimately, the patient will have to learn to negotiate anger and needs outside the session. Preparation can include mode dialogues—particularly dialogues among the abandoned/abused child, the healthy adult, and the angry and impulsive child. The optimal situation, typically, is that "the patient can express anger or assert her needs, but she must do it in an appropriate manner. . . . [For example,] the patient cannot yell at her boyfriend, but she can quietly tell him why she is upset" (Young et al., 2003, p. 351). As discussed earlier, the cognitive contribution to mode work is education about the role of emotion and the importance of anger. In the borderline constellation, anger was punished by the punitive parent; therefore, the patient frequently saw anger or being angry as "bad." This belief was probably reinforced by others who disliked his or her angry eruptions.

Autonomy

In the third stage, the autonomy stage, the therapy focus shifts from reparenting within the therapy relationship to developing independence outside sessions. The two primary areas of interest are interpersonal relationships and further development of a sense of identity.

Relationships, particularly intimate relationships, are explored to see how the various modes are interacting. Again, the hope is that the patient will be able to develop relationships in which she or he is neither oppressed nor deprived, on the one hand, nor enraged and destructive, on the other. Ideally, the patient can express needs appropriately and engage in give-and-take.

As has been clear throughout this discussion, a core sense of self is missing in BPD patients. The result is a lack of identity, a lack of a clear sense of self, which means that patients often do not know what they like, feel, or believe in. The therapist and patient can work together to explore the world, to find out what resonates with the patient. This is then used as a touchstone as the patient begins to make positive decisions in her or his life.

Special Considerations in Working With BPD Patients

Therapists engaged in schema therapy, while taking a compassionate approach to the treatment of BPD patients, are certainly not unaware of the difficulties that these kinds of patients can present. Young's (Young et al., 2003) basic text explores extensively core ideas that can be of use to therapists and may help them stay the course during difficult times. First, the mode framework itself provides psychotherapists with a framework for understanding the constantly changing phenomena that they are witnessing. After a session filled with connectedness, patients enter their next appointment filled with rage and threatening to quit therapy. It is not that the good work is lost; it is that the patient has been triggered in some way and has now switched modes. The ability to apply a label to these processes should, in and of itself, reduce stress.

Second, BPD patients are "needy, not greedy" (Young et al., 2003, p. 322). Treatment programs and therapists all too frequently envision these patients as making insatiable demands and seek to address this tendency through the use of limit setting. Schema therapy, as presented earlier, argues that these patients are psychologically and emotionally very young children who do not have adequate supports. This position causes great fear and anxiety. The core fear of abandonment, of being left alone in a dangerous situation, drives much of the demanding behavior. Young (Young et al., 2003) suggests that therapists superimpose an image of a young child on the face of the patient during difficult times. This technique helps the therapist to stay in a state of empathic connectedness.

Third, balancing the needs of both the patient and the therapist is an essential part of the model. Although schema therapy encourages therapists to be available for extra-session contact, it also gives them the ability to set boundaries on this availability. Contact may be limited to specific times and to specific vehicles of communication. The goal is for the therapists to feel comfortable while making attempts to meet the needs of these very deprived patients. The therapist's feeling resentment is counterproductive. Although this is a "limited reparenting" model, therapists cannot become true parents, even though patients may actually want them to be emotionally.

Fourth, this emphasis on balance extends to the difficult situations of anger and suicidality. Plans are drawn up to set limits on these behaviors while maintaining compassion for the patient. These limits are proposed for the well-being of the patient, the

therapist, and the therapy itself. Typically, anger controlling actions involve a series of escalating interventions. For anger, if the patient becomes abusive, he or she may have to go out and sit in the waiting room for 5 minutes. If this continues, he or she may have to forgo a session; if it continues longer, it may lead to a suspension or even a termination of therapy.

Finally, schema therapists are aware that BPD patients can trigger the therapist's own schemas and emotional issues. By taking stock of these, therapists can help understand and control their countertransferential reactions. All schema therapists are encouraged to participate in supervision of some sort.

Research Support

Research on schema therapy—both the schema-focused and schema-mode approaches—is currently under way. Major areas of investigation have included substance abuse (Ball, 2004), eating disorders (Waller, Ohanian, Meyer, & Osman, 2000), and borderline personality disorder and antisocial personality disorder (Lobbestael et al., 2005). Case reports focused on the impact of the schema mode model on severely disturbed patients (Bamber, 2004; Nordahl & Nysaeter, 2005) have also been published. While preliminary reports about its effectiveness show it to have some promise (Lobbestael et al., 2005), clearly there must be more rigorously controlled studies of schema therapy before its effectiveness as a treatment approach can be seen as established.

Conclusion

The treatment of borderline personality disorder through the use of mode work in schema therapy involves four healing mechanisms: "limited" reparenting, emotion-focused work (involving imagery and dialogues), cognitive restructuring and education, and behavioral pattern breaking. Through blending these strategies for change, the patient eventually develops a healthy adult mode, which leads to a greater ability to attain emotional stability, goal-directed behavior, mutually affirming relationships, and general well-being.

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