

**Schema Therapy for Borderline Personality Disorder: Patients' and  
Therapists' Perceptions**

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This thesis is presented for the degree of  
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I declare that this thesis is my own account of my research and contains as its main content work which has not previously been submitted for a degree at any tertiary education institution.

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## **ABSTRACT**

Schema therapy (ST) is effective in promoting clinically meaningful gains that ameliorate symptomatology for borderline personality disorder (BPD). However very little is known about how the therapy is experienced by patients or therapists including which elements of ST are effective from patients' and therapists' perspectives. The aim of this study is to explore BPD patients' experiences of receiving ST and therapists' experiences in delivering ST. Qualitative data were collected through semi-structured interviews with 11 patients who had a primary diagnosis of BPD and eight trained schema therapists. Interview data were analysed following the procedures of inductive, content analysis. Patients' broad perceptions of ST included the experience of greater self-understanding, better awareness of their own emotional processes and better connections with their emotions. While the process of ST was perceived as emotionally confronting, patient narratives highlighted that this was perceived as necessary. Therapists generally regarded their experience as rewarding based on patients' positive responses to treatment, and discussed changes made in their professional (e.g. incorporating more ST in their therapy) and personal (e.g. increased self-awareness) lives. However therapists also described being confronted with novel challenging situations despite having

years of therapy experience. Patients and therapists were concordant on several therapeutic components of ST (e.g. ST provides insight, benefits of experiential techniques) and some therapeutic group factors not specific to ST (e.g. sense of connection among group members). On the other hand there exists a possible interplay between level of patient dysfunction within the group and therapists' ability to manage group conflict. Recommendations for more effective implementation of schema therapy are discussed as well as issues for other specialist treatment approaches to BPD particularly concerning termination of therapy and definitions of recovery. Finally implications of the findings are discussed in terms of assessing the suitability of patients for group ST.

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## Chapter One: Introduction

### 1.1 Borderline Personality Disorder (BPD)

Borderline personality disorder (BPD) is a debilitating psychological condition causing substantial distress and functional impairment across many areas of life. Patients with BPD primarily suffer from problems including but not limited to impulsive behaviours, patterns of unstable affect and interpersonal relationships characterised by idealisation and devaluation, uncertain self-identities and acts of self-harm (American Psychological Association [APA], 2013). According to current psychiatric nosology, the Diagnostic and Statistical Manual of Mental Disorders – fifth edition (DSM-V) specifies that a diagnosis of <sup>1</sup>BPD requires at least five of the nine criteria summarised in Table 1. While there is no singular category “borderline personality disorder” in the International Classification of Diseases, 10th revision (ICD-10; World Health Organisation, 1994), an equivalent category F60.31 – “Emotionally unstable personality disorder, borderline type” exists. The psychoanalytic perspective of “borderline personality organisation” is more encompassing than these diagnostic classifications, and includes a broader range of psychological disorders.

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<sup>1</sup> Criteria for BPD remain unchanged from DSM-IV-TR

Table 1

*DSM-V diagnostic criteria for borderline personality disorder (301.83)*

- 
1. Frantic efforts to avoid real or imagined abandonment
  2. A pattern of unstable and intense interpersonal relationships characterised by alternating between extremes of idealisation and devaluation
  3. Identity disturbance: Notably 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 misuse, reckless driving, binge eating)
  5. Recurrent suicidal gestures, or threats or self-mutilating behavior
  6. Affective instability caused by a distinct reactivity of mood (eg, 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 ideation or severe dissociative symptoms
- 

### **1.1.1 Epidemiology of BPD**

In a nationwide epidemiological survey based on 10,641 respondents, lifetime prevalence of BPD within Australia was estimated to be 0.8% (Jackson & Burgess, 2004). A review conducted based on 11 epidemiological studies majority of which from the United States reported significantly higher mean-

median lifetime prevalence for BPD of 1.4-1.6% (Torgersen, 2012). BPD was also found to be the most commonly represented personality disorder in clinical populations, affecting an average of 28.5% of psychiatric patients comprising mostly outpatients (Torgersen).

Females are three times more likely to suffer from BPD in mental healthcare settings while no significant differences were found between males and females within community settings (National Collaborating Centre for Mental Health [NCCMH], 2009). This discrepancy may be attributed to the different manifestations of BPD symptoms in both genders. Men with BPD are more likely to suffer from substance abuse, aggressive and antisocial features, therefore presenting in correctional settings such as prisons. In contrast, women with BPD tend to have co-occurring diagnoses of PTSD or eating disorders and engage more in self-harming behaviours, therefore are more likely to present in mental health settings such as crisis services and the emergency department (Sansone & Sansone, 2011).

The onset of BPD typically begins during young adulthood, with symptoms becoming apparent in adolescence. While there may be some similarities between BPD markers and adolescent behaviour such as excessive sensitivity to rejection, interpersonal problems and self-harm, the presence of such manifestations increases the risk of developing BPD nine-fold (Winograd, Cohen, & Chen, 2008). Recent literature has documented high rates of remission (i.e. meeting less than three diagnostic criteria for BPD for more than 12 months) of 85% over 10 years (Gunderson et al., 2011) and 78% to 99% over 16 years (Zanarini, Frankenburg, Reich, & Fitzmaurice, 2012). However despite sustained remission, Gunderson et al. reported that only 25% of patients

held full-time jobs while 40% remained reliant on disability pensions even after 10 years. Recovery from BPD, as defined by symptomatic remission and classification of “good social and vocational functioning” was found in only 50% of patients after 16 years (Zanarini et al.). In addition, remission and recovery are more difficult to achieve with BPD compared to other personality disorders (Zanarini et al.). More often than not, there are high comorbidity rates with other psychiatric conditions, complicating the treatment course of BPD.

BPD patients generally have high rates of comorbidity, especially mood and anxiety disorders, disorders related to substance use and other personality disorders; up to 85% and 74% of BPD patients receive concurrent axis-I and axis-II diagnoses respectively (Grant et al., 2008; Lenzenweger et al., 2007). In particular, BPD is most frequently comorbid with major depression (Biskin & Paris, 2013; Zanarini et al., 1998). This combination of BPD with depression increases patients’ subjective levels of distress often leading to a higher frequency and severity of suicidal behaviour (Soloff, Lynch, Kelly, Malone, & Mann, 2000). Among personality disorders, paranoid, passive-aggressive and avoidant personality disorders are most frequently comorbid with BPD (Barrachina et al., 2011). A positive relationship was found between the number of axis-II comorbidities and the clinical severity of BPD (Barrachina et al.).

### **1.1.2 Impact of BPD**

While some individuals with BPD are able to lead fulfilling lives, many continue to suffer from a poor quality of life, requiring significant assistance from mental health services and support from friends and family. Skodol and

colleagues (2002) found that individuals with BPD have lower education attainment, greater functional impairment in occupational status, social relationships, leisure and recreation as compared to individuals with depression and obsessive-compulsive personality disorder. Not only does the continuous lack of productivity result in impairments to acquire and sustain employment, interpersonal difficulties often contribute to unstable and disrupted personal relationships. A variety of self-destructive and impulsive behaviours such as reckless driving, unsafe sex and eating problems are also common in this population. Additionally it was found that women with BPD reported higher self-stigma compared to women with social phobia (Rüsch et al., 2006), where self-stigma is described as an individual's internalised feelings of shame, guilt, diminished self-esteem and fear of discrimination associated with mental illness (Brohan, Slade, Clement, & Thornicroft, 2010).

Recurrent suicidal behaviour is a defining feature of BPD (Gunderson & Ridolfi, 2001; Sansone, 2004; Soloff & Fabio, 2008) and for this reason, BPD is often regarded as the most lethal form of mental illness and the most severe personality disorder (Chanen, McCutcheon, Jovev, Jackson, & McGorry, 2007). Stanley and Brodsky (2005) differentiated between two forms of deliberate suicidal behaviours; the first form consists of self-destructive acts with some intent to die while the second form involves non-suicidal self-harming behaviours. It was estimated that more than 75% of individuals with BPD engage in a repeated pattern of non-lethal (e.g. superficial cutting, burning) self-harming behaviours (Stanley & Brodsky) for a range of reasons such as distraction, anger expression and reconnection with their feelings (Brown, Comtois, & Linehan, 2002). Despite the absence of suicidal intent, the

risk of eventual suicide remains with repeated self-injury. In fact, a diagnosis of BPD was identified as the strongest predictor of suicide within a population with a history of inpatient psychiatric treatment (Tidemalm, Elofsson, Stefansson, Waern, & Runeson, 2005). Depending on the study methodology, completed suicides among individuals with BPD were estimated to be between approximately 8.5% (Paris, 2002) and 10% (Oldham, 2006).

In addition to emotional distress and functional impairment, the economic impact of BPD is significant; amounting to considerable financial costs to society. Rendu, Moran, Patel, Knapp and Mann (2002) explored the economic impact of personality disorders in the UK; the average cost for primary care attenders with a personality disorder diagnosis was estimated to be over £3,000 (A\$5,500) and approximately £1,600 (A\$3,000) to those without. These costs incurred included healthcare costs and productivity losses. A more recent study conducted by van Asselt, Dirksen, Arntz and Severens (2007) investigating the societal cost of BPD in the Netherlands reported the total annual cost of BPD to be €2.2 billion (A\$3.34 billion) based on 1.1% prevalence rate in a population of approximately 12 million. While only 22% of this cost figure is health-related, the remaining costs consisted of productivity losses, costs to criminal justice, informal care and out-of-pocket costs as a result of their lifestyles (e.g. cigarettes, phone bills).

Moreover, Soeteman, Hakkaart-van Roeyjn, Verheul, and Busschbach (2008) reported that treatment-seeking individuals with personality disorders place a substantially higher economic burden in the Netherlands as compared to other mental disorders such as depression and generalised anxiety disorder,



where the total cost of personality disorder was estimated to be €11,126 (A\$17,000) per patient. A study examining the treatment history of patients with personality disorders found that BPD patients received more extensive use of mental health resources such as individual therapy, group therapy, day treatment programs and a variety of pharmacological treatments when compared to patients with depression and other personality disorders (Bender et al., 2001). Similarly, Zanarini, Frankenburg, Hennen and Silk (2004) found that over 70% of patients who continued to engage in outpatient therapy after discharge are BPD patients. This chronic nature of BPD is reiterated in a study examining the use of mental health resources by patients with personality disorders over 10 years, which reported that regardless of the treatment modality (i.e. medication, hospitalisation or individual therapy), there is a cumulative increase of patients with BPD returning to therapy after termination (Hörz et al., 2010). These findings suggest that not only are individuals with BPD high treatment utilisers, it appears that the treatments received may be only partially effective.

Furthermore, due to the lack of appropriate services, comparatively more acute and crisis-related interventions in terms of visits to the emergency department, repeated psychiatric hospitalisation and inpatient stays were reported to be common among patients with BPD (Bender et al., 2006). While BPD patients may feel soothed and receive the care and attention they desire, such acute treatment settings are not therapeutic because they reinforce the unhelpful cycle of self-destructive behaviours, admission and readmission.

### **1.1.3 Aetiology of BPD**

The aetiology of BPD is complex; it is difficult to ascertain the exact causes of BPD and erroneous to suggest a convincing monocausal theory. There are several risk factors such as genetics, childhood trauma, adverse family interactions and environments that are associated with BPD and a combination of these are likely to contribute to its development (See Appendix A). In general, they reflect unsafe, deprived, invalidating and overly punitive family environments, often leading to feelings of isolation and rejection in the child. Parental nurturing in the form of guidance, protection and emotional connection is often deprived from one or both parents (Young, Klosko, & Weishaar, 2003). Due to their inter-correlations, caution must be taken when considering the unique contribution of each variable in the development of BPD. For example, childhood trauma is a significant risk factor of BPD, however it is not a prerequisite to BPD and it usually occurs within the context of a dysfunctional family environment and genetic vulnerability.

## **1.2 Limitations of Existing Treatment Modalities**

### **1.2.1 Pharmacological treatment**

The varied symptomatology of BPD might explain the prescription of different medication types. In a Cochrane systematic review, it was recommended that mood stabilisers (e.g. valproate semisodium, topiramate, lamotrigine) are effective for affect regulation and impulse-control symptoms. Findings also suggest that atypical antipsychotics (i.e. Aripiprazole) have beneficial effects on the cognitive-perceptual aspect of BPD while First Generation Antipsychotics such as Haloperidol and Flupentixol reduce anger

and suicidal behaviour respectively (Lieb, Völlm, Rucker, Timmer, & Stoffers, 2010).

However, consumer interviews have revealed that targeting individual symptoms of BPD commonly entails a prescription of a cocktail of psychotropic medications (Rogers & Acton, 2012), which may lead to a range of adverse drug interactions and/or side effects. Furthermore, medications typically present serious side effects such as sedation, tremors and dystonic reactions. At present, with the exception of managing crisis and reducing significant symptoms of depression such as insomnia, there is insufficient evidence for the use of any one drug in directly treating borderline personality disorder (National Institute for Health and Clinical Excellence, 2009).

### **1.2.2 Ineffectiveness of traditional Cognitive-Behavioural Therapy (CBT)**

Individuals with a diagnosis of BPD tend to be ambivalent about change and lack the compliance to follow through with treatment (Shearin & Linehan, 1994) therefore not presenting as ideal candidates for traditional cognitive therapy approaches. In therapy, such patients generally report poorly defined complaints with a diffuse presentation and non-specific triggers underpinned by characterological traits that create significant disturbance in personal relationships and intrapsychic development (Beck, Freeman, & Associates, 1990). Standard CBT is based on several assumptions including patients being motivated, compliant with treatment procedures and having the ability to access their cognitions and emotions (Young et al., 2003). Instead, BPD individuals display reluctance to complete monitoring tasks or learn self-control strategies (Linehan, 1993a; Stone, 2000). Many also detach themselves from painful

memories and distressing feelings therefore avoiding behaviours central to therapeutic progress (Linehan; Stone). As avoidance reinforces the reduction of negative affect and becoming increasingly habitual, therapeutic change becomes harder to achieve (Young et al.).

### **1.2.3 Specialist Psychological Interventions for BPD**

Over the last two decades, a variety of psychological treatments have emerged and have subsequently been manualised for patients with BPD. These included Dialectical Behavioural Therapy (DBT), Mentalisation Based Treatment (MBT), Systems Training for Emotional Predictability and Problem-Solving (STEPPS) and Schema Therapy (ST).

DBT is a manualised treatment developed by Linehan (1993) based on behavioural principles and the biosocial view that BPD is primarily the result of a dysfunctional emotional regulation system. It is now a widely used treatment for individuals with BPD, which involves four treatment modes; individual therapy, group therapy focusing on skills training, telephone contact and therapist consultation through peer support and supervision. The standard DBT program lasts for one year and involves weekly DBT group and individual sessions by DBT-trained therapists together with monthly supervision for the therapists (Linehan, Armstrong, Suarez, Allmon, & Heard, 1991).

The first RCT conducted on DBT for borderline patients was by Linehan, Heard and Armstrong (1993), where 44 participants who met the DSM-III criteria for BPD were allocated to either the DBT condition which included weekly 1-hour individual therapy and 2.5-hour group therapy or the treatment as usual (TAU) condition, which included optional alternative

individual therapy. Reduced parasuicidal behaviour, higher retention in therapy, less psychiatric inpatient days and cost savings were reported at treatment completion of 12 months (Linehan et al., 1991) and maintained at 1-year follow-up (Linehan et al., 1993). Since then, several treatment studies have emerged exploring the efficacy of DBT for BPD patients including female veterans (Koons et al., 2001) and comparing DBT with dynamic and supportive psychotherapies (Clarkin, Levy, Lenzenweger, & Kernberg, 2004; Levy et al., 2006) as well as individual psychotherapy delivered by experienced clinicians (Harned et al., 2008; Linehan et al., 2006b). More recently, DBT has been trialled with BPD patients in Australia within public mental health settings (Carter, Willcox, Lewin, Conrad, & Bendit, 2010; Pasieczny & Connor, 2011). In general, findings from these studies have largely replicated Linehan et al.'s initial study. However while the DBT program appeared to improve many areas of functioning in individuals with BPD, Carter et al. found no significant differences in deliberate self-harm, hospital admissions and length of stay between the DBT and control groups. Similarly, when the clinical efficacy of DBT was compared with general psychiatric management that included psychodynamically informed therapy and symptom-targeted medication management, individuals with BPD benefitted equally from both conditions (McMain et al., 2009). In addition, therapeutic outcomes were not generalised to important areas such as depression and hopelessness (Shearin & Linehan, 1994). Shearin and Linehan also found that the delivery of group DBT skills training alone without individual DBT was no different to the control condition. This implies that DBT is only effective when delivered as an inclusive program

rather than in combination with other non-DBT individual therapies or as a standalone DBT group skills program.

MBT is based on psychodynamic principles and has its roots in Bowlby's attachment theory and cognitive theory. Mentalisation is described as the process individuals make sense of themselves and their social world through mental states such as desires beliefs and emotions, which underpin interpersonal relationships. The emergence of borderline traits has been conceptualised as the failure to develop mentalising capacity during early childhood (Fonagy, 1991), and the MBT program was tailored to patients with BPD, with the aim of developing self-regulatory abilities and stabilising their sense of self (Bateman & Fonagy, 2004).

To date three randomised control trials have been published that reported the effectiveness of MBT with BPD patients. These studies compared MBT versus TAU (Bateman & Fonagy, 2008), MBT versus structured clinical management (SCM; Bateman & Fonagy, 2009) and MBT versus supportive group therapy (Jørgensen, Freund, Bøye, Jordet, Andersen & Kjølbbye, 2013).

In Bateman and Fonagy (2008)'s 8-year follow-up study diagnostic outcomes, suicidality, employment, service and medication uses have significantly improved in the MBT condition five years after therapy terminated. Over an 18-month period, 41 participants with a diagnosis of BPD either attended individual and group psychotherapy, together with a minor component of expressive therapy in the MBT condition or received standard psychiatric outpatient care and community support in the TAU condition. Participants in the MBT condition continued to receive MBT twice weekly for

an additional 18 months. While the results suggest positive effects of MBT in reducing borderline symptomatology, the absence of specialist psychotherapy in the TAU group over three years indicates these effects may be accounted for by the presence of intensive therapeutic input that was specifically targeted toward borderline symptoms, rather than the specific treatment per se.

Differences between the two conditions may be attributed to the structured therapeutic environment with large amounts of time spent in therapy rather than MBT itself, as evidenced by Bateman and Fonagy (2009)'s study which found substantial improvements after 18 months in both conditions: MBT and SCM. Patients in the MBT condition received twice weekly treatment while those in SCM also received twice weekly support but predominantly in the form of case management and problem solving. Because each condition utilised a combined group and individual therapy approach, it is possible that beneficial outcomes in the both conditions were explained by the group component instead of the MBT and problem-oriented components. Group factors such as group cohesiveness, encouragement and suggestions from group members facing similar difficulties have been found to benefit patients who attend group psychotherapy (Paley et al., 2013). A more recent study revealed apart from higher Global Assessment of Functioning (GAF) scores in the MBT condition, no significant differences between twice weekly combined group and individual MBT and fortnightly supportive group therapy over a two-year period (Jørgensen et al., 2013). The comparable outcomes between both conditions reiterated the benefits of a group approach regardless of intervention type.

STEPPS is a two-hour 20-week group program developed for outpatients with BPD that integrates cognitive-behavioural principles with the patients' available social and professional support system (Blum, Bartels, St. John, & Pfohl, 2002). STEPPS serves as a supplementary treatment with the aim of increasing patients' understanding of BPD and teaching them emotion and behaviour management skills (Black, Blum, Pfohl, & St. John, 2004). Graduates from the program may opt to repeat it or join the extension program STAIRWAYS, which represents Setting goals, Trying new things, Anger Management, Impulsivity control, Relationship behaviours, Writing a script, Assertiveness training, Your choices and STEPPing out revisited (Black et al.).

Blum et al. (2008) investigated the efficacy of STEPPS by comparing the treatment condition of STEPPS plus TAU to the control condition of TAU alone. Gains made in the treatment condition include improvements in impulsivity, negative affectivity, mood and overall global functioning. However, there were several concerns including high dropout rates in both conditions and the lack of significant differences in important variables such as suicide attempts, acts of self-harm and hospitalisation rates.

The complexity of borderline personality disorder poses difficulties to its treatment, where its nature interferes with successful treatment outcomes. For example, no-shows, turning up late, inconsistent appointments and not completing assigned homework tasks have been identified as common problems associated with this population (Stone, 2000; Linehan, 1993a). Additionally BPD individuals tended to be associated with high treatment dropout rates, which generally occur within three to six months from the start of therapy (Kelly et al., 1992; Waldinger & Gunderson, 1984). In therapy, such



patients generally report poorly defined complaints with a diffuse presentation and non-specific triggers underpinned by characterological traits that create significant disturbance in personal relationships and intrapsychic development. For these reasons, Young (1994) developed Schema Focused Therapy (SFT), subsequently known as Schema Therapy (ST) with a focus of treating patients who do not respond well to traditional cognitive therapy approaches.

Schema therapy is effective in treating range of disorders including posttraumatic stress disorder (PTSD; Cockram, Drummond, & Lee, 2010), anxiety related disorders (Gude & Hoffart, 2008; Hoffart & Sexton, 2002), cluster C personality traits (Gude, Monsen, & Hoffart, 2001), eating disorders (Simpson, Morrow, van Vreeswijk, & Reid, 2010), some personality disorders (Bamelis, Evers, Spinhoven, & Arntz, 2013), co-occurring substance misuse (Ball, 2007; Ball et al., 2005) and borderline personality disorder (Dickhaut & Arntz, 2014; Farrell, Shaw, & Webber, 2009; Giesen-Bloo et al., 2006; Nadort et al., 2009; Nordahl & Nysæter, 2005).

### **1.3 Development of Schema Therapy for BPD**

Schema therapy is an integrative treatment modality that incorporates concepts from a range of approaches including cognitive-behavioural therapy, object-relations, attachment theories, gestalt therapy and psychodynamic perspectives (Young, 1999). Specifically, it comprises experiential techniques and strongly emphasises on the therapeutic relationship as an impetus for cognitive and behavioural change. Schema Therapy focuses on early maladaptive schemas (EMS), which are described as pervasive self-defeating and dysfunctional patterns of interactions in one's interpersonal relationships

and within oneself that are developed during childhood or adolescence and persist throughout adulthood (Young, 1999). The existence of EMS has been supported by an increasing body of research (Schmidt, Joiner, & Telch, 1995); they develop as a result of emotional needs that were unmet in childhood, triggered by life events that activate memories of those adverse childhood environments and are often accompanied by intense negative emotions.

Individuals with BPD often experience rapid emotional changes, with concurrent activation of several schemata (Young et al., 2003). A BPD patient may present certain schemas (e.g. punitiveness) and dysfunctional coping strategies (e.g. self-cutting behaviours) at the same time. Such schema operations: the combination of schemas and coping responses, reflect the concept of schema modes (Bamber, 2004; Kellogg & Young, 2006). Schema modes may primarily consist of multiple schemas and represent the individual's cognitive processes, emotions and behaviours at a given point in time (Lobbestael, van Vreeswijk & Arntz, 2007).

Several modes exist within each individual and they may be defined as parts of the self, symbolising aspects of an individual's personality. Among healthy individuals, modes are well integrated and represent a unified sense of self. On the other hand, the internal world of a BPD patient tends to be fragmented and more disintegrated. That is to say, there is some level of identity disturbance which is associated with abrupt "flipping" from one mode to another. The borderline constellation was hypothesised to consist of five central modes within the four aforementioned mode groups: the Abandoned/Abused child, the Angry/Impulsive child (child modes), the Punitive Parent (maladaptive parent mode), the Detached Protector

(maladaptive coping mode) and the Healthy Adult (healthy adult mode) (Young et al., 2003). More recently in an empirical study conducted by Arntz, Klokman and Sieswerda (2005), it was found that the BPD group scored significantly higher on these four mode subscales (i.e. Detached Protector, Punishing Parent, Angry Child, Abandoned/Abused Child) and lowest on the Healthy Adult mode as compared to the cluster C Personality Disorder and control groups. This supports the hypothesis that these mode subscales exist in individuals with BPD (See Appendix B).

### **1.3.1 Mechanisms of Schema Therapy for BPD**

The overall goal of ST is to nurture and cultivate the Healthy Adult mode in borderline patients “in order to protect the abandoned child, to teach the angry and impulsive child more appropriate ways of expressing anger and getting needs met, to defeat and expel the punitive parent, and to gradually replace the detached protector” (Young et al., 2003, p. 308). All in all, the therapist must provide what was absent in the patient’s childhood but needed for a healthy development.

An essential part of therapy is the concept of “limited re-parenting” where the therapist enters the therapeutic relationship and models the supportive parental behaviours, consistent with the Healthy Adult mode. This implies the importance of a safe and trusting therapeutic environment and relationship between the therapist and the borderline patient. When necessary, after-hours contact is made available to the patients in times of crises such as suicide attempts (Kellogg & Young, 2006).

Imagery rescripting is one of the most used experiential techniques in schema therapy. It assists the borderline patient to recreate and alter parts of a situation so as to change the experience of that past event. Its effectiveness and value has been documented with a range of disorders (Arntz, 2012; Arntz & Weertman, 1999; Brewin et al., 2009; ten Napel-Schutz, Abma, Bamelis, & Arntz, 2011). Other experiential techniques employed in ST in the treatment of BPD include letter writing and the use of chair dialogues. While letter writing allows borderline patients to express their feelings, both positive and negative, dialogues and roleplays help promote the separation of the internalised punitive parent from the core self (Kellogg & Young, 2006). These experiential techniques work with the “hot” cognitions at an emotional level to more readily access the unmet core needs. Together with the process of limited reparenting, they enable the borderline patient to progress from an intellectual awareness of how their schemas were developed to truly understanding why they follow certain paths of behaviour and how early maladaptive schemas contribute to their present day personalities.

Cognitive techniques involve both psychoeducation and cognitive restructuring. The education component validates individuals with BPD, and their right to express their needs and emotions in appropriate situations. At the same time, the cognitive restructuring component utilises Socratic dialogue and different visual aids such as pie charts and analogue scales aimed at helping the borderline patient to adopt a less dichotomous way of thinking (Arntz & van Genderen, 2012). The final therapy phase of behavioural pattern breaking consists of behavioural techniques such completing homework, skills training and graduated exposure to problem-solve so that dysfunctional patterns of

behaviours can be circumvented and be replaced with healthier alternatives (Young et al., 2003). For example, practising and actively applying assertiveness skills would gradually help ground individuals in specific practical life situations.

### **1.3.2 Limitations of published articles on Individual and Group Schema Therapy**

Schema therapy can be delivered in a group and more commonly in an individual format or combined group and individual format. To date, there exist few empirical research studies exploring the effectiveness of schema therapy on borderline personality disorder. Five published papers have been identified examining the efficacy of ST specifically on borderline personality disorder using a case series design (Nordahl & Nysæter, 2005), by comparing against transference-focused therapy (Giesen-Bloo et al., 2006), the effectiveness of schema therapy within regular mental healthcare settings with and without crisis telephone support outside office hours (Nadort et al., 2009), within a group format (Farrell et al., 2009) and a combined group and individual format (Dickhaut & Arntz, 2014). There has only been one outcome study (van Asselt et al., 2008) considering additional parameters including total costs spent on accessing healthcare facilities and products.

Nordahl and Nysæter (2005) employed a case series design where participants consisting of six female borderline outpatients from ages 19 to 42 years old acted as their own controls. Participants received weekly 60-minute individual ST between 18 to 36 months, with a mean period of 22 months. Treatment faded approximately six months before the end of therapy. Results

indicated large effect sizes of 1.8 to 2.9 between pre-treatment and follow-up regarding positive changes on maladaptive schemas, improvement on general adaptive level of functioning and scores on symptomatic and interpersonal distress. Additionally three of six participants no longer fulfilled criteria for BPD. However the schema therapist had the dual role of the conducting the assessments at different time points during the course of therapy. The lack of an independent assessor suggests the possibility of therapist and participant biases, which may limit the validity of the results.

Giesen-Bloo et al. (2006) compared the effectiveness of ST and transference focused psychotherapy (TFP) on 86 participants diagnosed with BPD. In both treatment conditions, 50-minute sessions were offered twice weekly which gradually reduced in frequency over a period of three years. While both treatments produced apparent significant improvements in terms of reductions in all BPD symptoms and psychopathological dysfunction specific to BPD and increased quality of life at the 12-month mark, the ST condition exceeded that of the TFP condition on all BPD measures; medium to large effect sizes of between .43 and 1.03 and small to large effect sizes of between .09 and .99 in the ST and TFP conditions respectively. However, the generalisability of the beneficial outcomes for both therapies was noted as a concern due to the high frequency of therapeutic work. Some patients may not have the financial resources to commit to the intensity of the treatment and similarly as cited in Masley, Gillanders, Simpson and Taylor (2011), some healthcare settings are also unable to support the biweekly treatment program for three years. Not only were lower dropout rates associated with the ST condition (26.7% versus 52.4%), the outcome study by van Asselt and

colleagues (2008) suggested a moderate to high probability that ST was more cost-effective than TFP. These results were based on conducting three-month retrospective structured cost interviews, which assessed costs relevant to each participant's personality disorder including work absences, medications, expenses on healthcare resources such as visits to hospitals and general practitioner, informal care from caregivers and etcetera.

In a more recent study conducted in the Netherlands, the implementation of ST to borderline outpatients in regular mental healthcare settings was assessed together with the possible added value of after-hours therapist telephone support by allocating participants ( $n = 62$ ) to either the treatment condition with or without telephone crisis support (Nadort et al., 2009). All participants attended 45-minute ST biweekly for the first year, which tapered to once a week in the second year. It was found that both conditions generated clinically significant reductions in BPD symptoms including abandonment, unstable relationships and parasuicidality. Interestingly, results also indicated that there was no added benefit of extra therapist support outside office hours in terms of treatment outcomes and dropout rates. Implications from these findings suggest the feasibility and accessibility of ST for BPD in general healthcare settings, including those that are not established for out-of-hours support.

### **1.3.3 Group Schema Therapy (GST)**

Group schema therapy (GST) has shown promising results with BPD symptomatology, as demonstrated in Farrell and colleagues' (2009) study. At present, this is the only randomised control trial conducted on GST with a

specific focus on BPD. GST plus individual psychotherapy were compared to individual psychotherapy on its own (TAU). Participants were 32 female borderline outpatients with an age range of 22 and 52 years old. At the eighth month follow-up, participants in the GST plus individual therapy condition reported improved overall functioning, significant reductions in borderline symptoms and global severity of psychiatric symptoms. Similarly the proportion of participants who no longer met criteria for BPD was significantly higher among participants attending GST (94%) compared to the TAU group (16%). However these clinical gains in the GST may not necessarily be entirely attributed to ST. The schema condition received a higher frequency of an additional 90-minute weekly clinical contact, which can be in itself therapeutic regardless of the type of therapy. There is also a specific focus on targeting borderline symptoms in the schema condition whereas there was an absence of BPD specialisation in the TAU condition, again possibly inflating the benefits of the ST component.

It was suggested that ST could be more efficacious when delivered in a group setting due to the capacity for group members to share similar experiences (Farrell & Shaw, 2012). Individuals with BPD tend to grow up in families that are harshly punitive and depriving, leading to them feeling isolated and distant from others (Young et al., 2003). In this sense, GST can facilitate the sense of belonging and acceptance (Farrell & Shaw). In addition, Simpson and colleagues (2010) piloted GST with eight participants with chronic eating disorders over 18 weekly 2-hour sessions. At the six-month follow-up, six of eight participants showed significant improvements on symptoms of eating disorder, schema severity and quality of life with large



effect sizes of 1.00 to 1.59, suggesting clinical efficacy of GST for eating disorders. GST was reported as a positive experience for group members in being able to challenge their long-standing schemas at a collective group level and in feeling safe and less isolated (Simpson et al.).

### **1.3.4 Combined Group and Individual Schema Therapy**

Dickhaut and Arntz (2014) piloted a study that explored the efficacy of combined group and individual format for ST with two cohorts of BPD patients: the first was conducted with therapists with individual ST experience but not group and the second was conducted with therapists who were trained by group ST specialists. ST was delivered on a weekly basis over a two-year time duration with individual ST offered up to six months after its conclusion. Findings reflected the effectiveness of this combined format through significantly improved scores on BPD symptomatology, quality of life and identification with dysfunctional schema modes. However no significant cohort differences were found.

When comparing against aforementioned studies regarding the impact of ST on BPD the combined format appeared to have a higher recovery rate than individual ST in previous studies (Giesen-Bloo et al., 2006; Nadort et al., 2009) as reflected by higher effect sizes found on the Borderline Personality Disorder Severity Index (BPDSI; Dickhaut & Arntz, 2014). These findings implied the therapeutic benefits of group ST.

Despite the large benefits apparent in these studies, therapeutic group processes accompany the nature of group psychotherapy and it may be erroneous to attribute treatment success exclusively to factors embedded in

schema therapy. Yalom (1995) identified “cohesion” as a central tenet in and unique to group therapy. The act of sharing similar experiences and sense of belonging to group members may account for the improved outcomes. Hence it is certainly of value to further investigate specific and non-specific factors that contribute to the published benefits of schema therapy delivered in a group format.

#### **1.4 Therapists’ and Patients’ Perceptions of Therapy**

Over the years, there has been increasing interest in consumers’ perspectives regarding their experience of treatment (or their lack of) and the quality of services received. A recent national survey of individuals with BPD conducted by the Private Mental Health Consumer Carer Network (PMHCCN) revealed long-term psychotherapy, comprehensive psychoeducation, identification of early warning signs and consistent support are helpful in managing BPD (McMahon & Lawn, 2011). Despite the knowledge of quantitative outcomes and preliminary understanding of BPD patients’ experience of therapy, thorough and therapy specific qualitative analysis is lacking.

##### **1.4.1 Patients’ Perspectives of Recovery from BPD**

Katsakou and colleagues (2012) investigated patients’ interpretations of recovery from BPD with the aim of assessing the extent to which mental health services supported patients’ personal goals. Interview themes revealed various conceptualisations of recovery from BPD including improved confidence, relationships and ability to regulate emotions. Findings also indicated specialist psychotherapies such as DBT and MBT that directly addressed BPD symptoms

had an overly narrow focus: DBT on self-harming behaviours and emotional regulation, MBT on relationship problems. Other specialist psychotherapies such as TFP and ST aimed for a broader focus, working beyond symptomatic profiles which can lead to more meaningful changes and a higher quality of life (Katsakou et al.). It would therefore be of value to assess how service users experience ST and tease out the specific aspects of ST that facilitate this process.

#### **1.4.2 Patients' Perspectives of Imagery**

Specific to ST, research on patient perspective treatment is limited to one paper that explored patients' perspectives on imagery work within the context of ST (ten Napel-Schutz et al., 2011). However, no research has examined the therapeutic mechanisms of ST from the perspective of the patients. In ten Napel-Schutz and colleagues' study, 10 individuals with a diagnosis of personality disorders including paranoid, narcissistic and cluster C personality disorders participated in semi-structured interviews that discussed early imagery techniques such as diagnostic imagery and imagery of a safe place. Analyses of the patients' experiences found that it was essential to clearly and fully explain what the imagery exercise entails from the beginning, provide a fixed duration of time for the imagery exercise and take caution to prevent pathologising the patients if they faced visualisation difficulties (ten Napel-Schutz et al.). Findings from this study were useful in refining the protocol of imagery techniques in the delivery of ST. However in addition to imagery, ST consists of several other techniques and having an understanding

of patients' experiences and perspectives would illuminate the therapeutic components and impact of ST.

### **1.4.3 Differing Perceptions of Therapy**

No study to date has considered the experiences of both patients and therapists in ST and compared the differences between individual and group ST. Research has however found differences between therapists' and patients' perceptions of helpful and important aspects of therapy (Bloch & Reibstein, 1980; Llewelyn, 1988). More recently, therapists' and patients' experiences within specific psychotherapies also differed, such as Solution-Focused Brief Therapy (Metcalf & Thomas, 1994) and DBT (Araminta, 2000). These findings suggest that despite sharing the same therapy space, experiences can be interpreted differently and involving all parties in therapy could present a more holistic and comprehensive picture.

Llewelyn (1988) studied responses from 26 therapist-client pairs regarding the helpful and unhelpful aspects of therapy. The majority of the therapists in this study employed an eclectic approach. It was found that while therapists rated cognitive and affective insights as most helpful, clients reported reassurance, problem solving and personal contact as most helpful during therapy (Llewelyn). It was concluded that a balance is needed to achieve therapeutic change; overemphasis on helping clients gain insight without sufficient personal contact and reassurance may be inefficient and less valuable. Similarly, in an earlier study by Bloch and Reibstein (1980), 33 patients with a diagnosis of a personality disorder or traits of neuroticism were divided among six groups run by six pairs of therapists. Patients and therapists completed The

Most Important Event questionnaire in fixed intervals during the course of therapy. The findings revealed that therapists placed most value on behavioural factors while patients rated cognitive factors as most important in therapy (Bloch & Reibstein), indicating a divergence in overall perceptions between therapists and patients.

Discrepancies in therapy experiences in DBT between individuals with BPD and therapists also emerged in Araminta's (2000) study. While most of the 10 BPD clients described therapist self-disclosure as very helpful in establishing a sense of connection, DBT therapists rated therapy tasks and their irreverent communication styles as most salient in DBT (Araminta). Findings have led to clinical implications including the necessary accompaniment of group therapy component to individual therapy in DBT and possible increased use of therapist-self-disclosure, contradictory to traditional psychoanalytic practices (Araminta). In another qualitative study that interviewed 10 BPD patients and 4 therapists on their perceptions of receiving and giving DBT respectively, both participant groups were in agreement of the effective components of DBT and these included respectful attitudes and the support of the therapy contract (Perseius, Ojehagen, Ekdahl, Asberg & Samuelsson, 2003). However because negative experiences of DBT were not explored in this study, apart from ascertaining the therapeutic aspects of DBT, findings are limited in informing future delivery of DBT for BPD.

Findings from the aforementioned studies demonstrate that aspects of therapy hold different levels of salience for therapists and clients, which underscores the value of understanding clients' experiences of therapy in

facilitating therapeutic events. Given the difficulty of engaging individuals with BPD in treatment and their high drop out rates, it is even more essential to learn how they experience therapy so as to elucidate the important therapy ingredients and how they can be more palatable for such populations. At the same time, individuals with BPD can be highly dependent and attached to their therapists and it is not uncommon for therapists to feel frustrated and incapable, potentially leading to burnout due to the significant time and effort required (Lord, 2007; National Health Care for the Homeless Council, 2003). For these reasons, including schema therapists' perceptions in the research would generate value not only in informing how consistent events in ST are interpreted by patients and therapists but also provide insight into the therapeutic aspects of individual and group ST and how ST differed from their previous therapy experiences. Another interest is how therapists experience ST training and supervision. These this can help enhance the delivery of individual and group ST.

### **1.5 Rationale for Present Study**

The limited efficacy rate of existing treatment modalities for BPD highlights the need to explore other treatment models that serve to support recovery. There is now convincing evidence that individual and group ST are effective in promoting clinically meaningful gains that ameliorate borderline symptomatology and quality of life. Nonetheless, there remains scope to further explore the specific beneficial aspects of individual and group ST, particularly beyond existing quantifiable measures to include broader experiences such as challenges faced and therapeutic relationships. Furthermore, the limited number of randomised control trials of ST for BPD together with an under-developed

applicability of GST to BPD leads to a strong case for more thorough research. It is especially important that this research accounts for the ways ST shapes recovery from BPD and the various contexts and interactions that define the reciprocal relationships between therapist and patient. Only by identifying the specific therapeutic assets within the therapeutic environment of ST can one begin to understand more holistically how ST induces these benefits. The gaps and problems identified in the existing literature point to the need for more detailed research on the impact of ST on individuals recovering from BPD. More specifically, the identification of therapeutic ingredients that ST potentially provides to facilitate recovery will likely have significant implications for its delivery and the design of novel community mental health care initiatives. More importantly, patients and therapists provide valuable insight to what is potentially missing from the current therapeutic protocol. The use of a qualitative research design is indicated for the exploratory nature of this study in generating preliminary findings that might inform more diverse studies in the future.

### **1.5.1 Research Aims and Implications**

The aim of this study is to explore BPD patients' and therapists' experiences of receiving and delivering ST respectively. In particular, this study will seek to:

- (1) Examine specifically what aspects of individual and group schema therapy were helpful (unhelpful) in facilitating (hindering) recovery.
- (2) Investigate patients' and therapists' experience of group processes present in group schema therapy.

- (3) Explore patients' opinions about their respective formats (i.e. Combined group and individual ST condition or Group ST condition) to assess what the optimal format of ST is for BPD.
- (4) Explore and compare any differences between therapists' and patients' perceptions (e.g. challenges/difficulties) of ST.

Findings of the study will not only assess the consistency of interpretation of certain events by patients and therapists and provide knowledge on the specific therapeutic ingredients, which have the most impact for individuals with BPD, but also potentially enhance the delivery of ST for such populations. Additionally, therapist narratives may inform other therapists who are interested in conducting ST in the future regarding their experiences including challenges and self-care strategies.



## Chapter Two: Method – Patient Participants

### 2.1 Patient Profiles

Two groups of participants were included in this study: a patient group and a therapist group. In this section, only the patient profiles will be included. The patients have been assigned to the treatment condition as part of an international, multicentre randomised controlled trial (RCT) conducted across six countries in over 14 sites. The research aims to compare the effectiveness between GST and treatment as usual (TAU) in the treatment of BPD and investigate the most optimal format for delivering schema therapy (Wetzelaer et al., 2014). Patients with the diagnosis or query diagnosis of BPD within the South Metropolitan Area Health Service, specifically Rockingham and Peel were invited to participate through new referrals or if they were already receiving treatment for BPD with the service.

Twelve participants in the patient group were initially invited to take part in this qualitative study however one of them declined. The remaining 11 patients recruited consisted of two males and nine females aged between 24 and 59 years old with a primary diagnosis of borderline personality disorder according to the DSM-IV and DSM-V and have met the inclusion criteria (See Appendix C). All participants ( $n = 11$ ) in the patient group had been involved in the Schema Therapy study for at least 12 and up to 22 months and were invited to participate after the study's aims and procedures had been explained to them. Patient participants at the Rockingham site ( $n = 7$ ) received a combination of weekly group and individual ST for the first 12 months, which decreased to fortnightly sessions in the next six months and subsequently monthly sessions in the remaining six months. Patient participants at Peel ( $n = 4$ ) received twice-

weekly group ST with an optional bank of 12 individual ST sessions in the first 12 months, which decreased to weekly group ST with an optional bank of 6 individual ST sessions in the next 6 months followed by only monthly group ST in the last 6 months. Group ST sessions were 120 minutes each while individual ST sessions generally lasted between 50 to 120 minutes. Patient participant characteristics and therapy conditions are displayed in Table 2 below.

Table 2

*Patient Participant Characteristics*

Patient Code	Gender	Age (years)	ST Site	Therapy Condition	Length of ST prior to interview
5230	F	48	Rockingham	Combination	18 months
5216	M	24	Rockingham	Combination	18 months
5221	F	45	Rockingham	Combination	18 months
5233	F	55	Rockingham	Combination	21 months
5206	F	46	Rockingham	Combination	12 months
5211	F	32	Rockingham	Combination	22 months
5224	M	26	Rockingham	Combination	12 months
5011	F	59	Peel	Group ST	16 months
5033	F	30	Peel	Group ST	12 months
5025	F	42	Peel	Group ST	18 months
5002	F	50	Peel	Group ST	16 months

**2.2 Procedure**

There were two dropouts; one patient at Peel discontinued after 12 months of therapy while another at Rockingham was convicted and imprisoned 12 months into the course of therapy. However, both were invited and had agreed to participate in the interviews. Therefore all patients have completed at least one year of ST. Apart from one interview being conducted within prison

grounds, the remaining 10 patient interviews were conducted in office rooms at Rockingham or Peel mental health services. Each patient participant was given a movie ticket worth AUD\$15.00 in appreciation of their participation. An information letter (See Appendix D) outlining the study's aims, procedures, risks and benefits of participation was provided and explained to them prior to obtaining their informed consent (See Appendix E). Should any negative experience occur as a result of the interview process, patients were informed that they would be fully attended to by their respective case managers and/or therapists. No evident distress was noted during or after the interviews. While information derived from these interviews included direct quotes and personal experiences, to protect anonymity, all identifying data were either de-identified or excluded.

The Topic List for BPD patients (See Appendix F) was developed to guide the in depth semi-structured interviews conducted. This Topic List was constructed after various discussions with the research team comprising researchers with academic and clinical backgrounds as well as a pilot interview with a service user with BPD. For each topic, examples of open-ended questions were provided however there was no obligation to use them, especially not when topics were already addressed spontaneously. A flexible interview style was adopted and the topic list served to guide the interview rather than dictate it. Significant areas that arose were further explored and probed following the patients' interests and concerns.

Interviews in this patient group lasted between 60 and 180 minutes. The patient interview conducted on prison grounds could not be audio recorded but interview content was written down. All other interviews were audio-recorded

with a digital recorder and transcribed verbatim. Subsequently, a member check or informant feedback was sent via email or post to each patient to comment and correct if necessary. In this way, the integrity and authenticity of the data was preserved. Additionally the interviewer was independent to the study and had not met any of the participants before the study.

### **2.3 Data Analysis**

Interview data were analysed following the systematic, analytic procedures of qualitative content analysis (QCA), which has been described as “a research method for the subjective interpretation of the content of text data through the systematic classification process of coding and identifying themes or patterns” (Hsieh & Shannon, 2005, p.1278). This approach aims to develop explanations on processes and interactions on the topic (i.e. experiences of receiving and delivering schema therapy). Because this is an exploratory study of patients’ and therapists’ experiences of schema therapy, there were no hypotheses permitting a large degree of flexibility beyond the researcher’s analytic preconceptions.

The process of data analysis began with being immersed in the data, repeatedly reading the interview transcripts with an unbiased perspective to gain familiarity with and generate an overall impression of the data. Relevant passages or texts that came across as meaningful were then extracted and organised into categories and subcategories. These were subsequently grouped accordingly to the research questions that participants responded to. Categories and subcategories not limited to the apriori formulated ones were also created.

### **2.4 Inter-Coder Agreement**

To construct the preliminary coding frame, an independent Dutch researcher who practises as a registered psychologist within an eclectic orientation, together with the interviewer/author coded a sample of eight transcripts (i.e. two Dutch, three German, three Australian) from the patient interviews. Any disagreements were discussed until both coders agreed on the naming of each category and theme as well as the appropriate placement of each interview passage. In addition the research team consisting of three academic researchers with clinical expertise provided feedback and further refinement of core themes generated from the international interviews. Following this a third researcher, a clinical psychology Masters student, also Dutch, coded another 20 interview transcripts (i.e. 6 Dutch, 7 German, 7 Australian) not used in the initial assessment of themes. These tapes and the subsequent discussion on themes allowed for revisions where new themes were added and existing themes merged to capture a more robust and accurate representation of the interview data. The final agreed codes were then subject to analysis using a qualitative software program MAXQDA. Owing to the separate sites both coders were working from, data set from one source was exported so that both data sets could be merged for calculating the inter-coder agreement or Cohen's Kappa (Cohen, 1960).

Cohen's Kappa was used as the assessment of inter-coder reliability in the current study rather than other statistics (e.g. coefficient of agreement) as it corrects for chance agreement between coders, reducing inflation of reliability scores (Cohen, 1960). The Kappa measure commonly ranges from +1 (perfect agreement) to 0 (agreement no better than chance). On the other hand negative values are uncommon and indicate a level of disagreement greater than

expected by chance. While there exists some variance on what constitutes an appropriate cut-off for Cohen's Kappa, an estimated value of at least .70 is sufficient for good inter-rater reliability of the interview data (Cicchetti, 1994).

The inter-coder agreement function used in MAXQDA measured the level of agreement for each individual segment in every interview transcript. Segment agreement was recommended as the most precise criterion and is often used in qualitative research (MAXQDA software for qualitative data analysis, 1989-2014). Therefore to ensure the quality of the analyses and reliability of the data, only segments coded by both coders were considered in agreement.

To calculate Cohen's Kappa for each topic/category a contingency table was created utilising a 95 percent confidence interval. MAXQDA generates an output table with all segments jointly coded for each topic/category displaying the segments agreed by both coders, segments coded by the interviewer but not the third researcher and segments coded by the third researcher but not the interviewer. These were recorded in the contingency table together with the total number of coded segments (i.e. 2037) and both coders separately calculated Cohen's Kappa for each topic/category within the coding frame. Topics/Categories where Cohen's Kappa was below .70 were discussed in greater detail. Topics/categories that were initially below .70 included "Expectations, feelings and beliefs prior to and after starting ST" and "Perceptions of ST as compared to previous therapies". Disagreements were resolved by selecting and further analysing up to two transcripts that had the lowest agreement by coded segments. The process of deriving the final Kappa values took approximately eight hours of discussion (via Skype) between both

coders. Results of inter-coder reliability for each topic/category are displayed in Table 3.

Table 3

*Inter-Coder Agreement for each Topic/Category*

<b>Topic/Category</b>	<b>Cohen's Kappa</b>
<b>Part One: General experiences of Schema Therapy</b>	
Benefits gained and difficulties faced in ST	.729
Perceptions of ST as compared to previous therapies	.740
Expectations, feelings and beliefs prior to and after starting ST	.722
<b>Part Two: Group and Individual components of ST</b>	
Group experiences and dynamics	.716
Structure and format of group and individual therapy	.745
Relationship with group and individual therapists	.795

## **2.5 Interview data specific to the Australian site**

There were 11 Australian interview transcripts in total out of which 10 were used to develop the coding frame and calculate Cohen's Kappa. Once the recommended Cohen's Kappa cut-off of at least .70 was achieved based on 20 interviews (i.e. 6 Dutch, 7 German, 7 Australian), the interviewer coded the remaining Australian interview transcript in MAXQDA according to the finalised coding frame. Results of patients' interviews are presented and discussed in the following chapters.

### **Chapter Three: Results – Patient Participants**

Nine patients appeared forthcoming while two came across as more guarded when relating their experiences of schema therapy (ST). While everyone reported positive changes made as a result of ST, one of them also described feelings of regret having participated in it. Based on the discussions, this patient participant results section is divided into two parts: the first involved patients' general experiences of ST, the second addressed more specifically its group and individual components.

#### **3.1 Part One: General experiences of Schema Therapy**

Various themes relating to patients' broad perceptions of ST are summarised in Table 4; beginning with A) Benefits gained and difficulties faced in ST, followed by patients' B) Perceptions of ST as compared to previous therapies, together with their C) Expectations, feelings and beliefs prior to and after starting ST.



Table 4

*Patients' Broad Perceptions of Schema Therapy*

Topic/Category	Themes/Subcategories	n
A. Benefits gained and difficulties faced in ST	Extent to which ST provided insight	10
	Changes of connection with one's emotions	6
	Ability to see things from different perspectives and applies skills learnt	5
	Change in confidence levels and assertiveness	4
	Changes associated with feelings of fear	4
	Extent to which ST minimised harshness to self	4
	Necessity of difficulty level in ST	4
	B. Perceptions of ST as compared to previous therapies	Degree of focus on internal processes
Acknowledgement/focus on the past		4
Extent to which ST was prescriptive and tailored to individual needs		3
Practicality of the provision/teaching of alternative ways of coping		3
C. Expectations, feelings and beliefs prior to and after starting ST	Indications/attitudes of hope and openness	5
	Expectation levels	4
	Extent to which ST surpassed expectations	4

**3.1.1 A. Therapeutic and challenging aspects of ST in general**

All patients reported therapeutic gains as a result of ST and these were categorised across six themes described below. While four patients also experienced difficulties in ST primarily due to revisiting past trauma they explained that undergoing the processes was necessary in facilitating the beneficial changes.

**A1. Extent to which ST provided insight**

Ten patients endorsed the idea that ST provided insight and described ST facilitated understanding of the self and internal processes while making sense of their problems and reactions to life events. Prior to ST patients described reacting in disproportionate ways to certain situations or maladaptive behaviour patterns in the past including impulsivity, aggression and cutting. Patients indicated ST had provided logical explanations, which make sense of their behaviours. *“With schema we started off by getting an understanding of our condition and so that gives you, well for me anyway- more of a knowledge of why you’re reacting the way you’re reacting or why you’re doing the things you’re doing rather than that’s just because you’ve got depression- and for me, that makes a lot more sense... It’s like explaining to a diabetic why their body doesn’t produce the insulin, it’s like explaining to us why the borderline personality has come about”* (patient 5206). Patients also mentioned being more able to recognise and identify their triggers. *“When I look back on it through schema modes I can see the situations where I was impulsive but even being impulsive there was still that sense of demanding- to be in control, so I would be impulsive in a controlled sort of way. I intellectualise everything from a very early age without realising that’s what I was doing but that was my way of coping with the whole fear of rejection and loss and hurt... without being consciously aware of that until I had done schema”* (patient 5002).

#### A2. Changes of connection with one’s emotions

Six patients described how ST has led to increased connection of and/or awareness with one’s emotions and being vulnerable. Patients expressed they had never perceived themselves as vulnerable and that it was difficult for them

to access their emotions. However the therapy has allowed them to get in touch or reconnect with the feelings or emotions that have previously been blocked or detached. A patient described the shift from intellectualising in the past to developing the ability to connect emotionally. *“I mean I could sit there and tell you about all the times<sup>2</sup> it had happened but I wouldn’t connect to it emotionally, and schema sort of reconnected the emotional side of me, I had to reconnect with that feeling of being hurt and that it wasn’t right.. I was intellectualising it too much, I wanted to understand it and that was frustrating... it was almost like once I started being vulnerable and it just felt like it was sad and I wanted to cry all the time. It’s like I couldn’t disconnect from that being vulnerable”* (patient 5002). Another patient described her reconnection with positive emotions. *“About three months ago I started laughing, laughing...really laughing. Like I’d see something on the tele and I’d laugh out loud, and all my neighbours have said ‘It’s so good to hear you laugh again’ ... I had no feeling, nothing was funny, nothing was interesting. It was like my brain had shut down... and it’s not only realizing that you’re starting to think properly and that things are coming back into line for you- it’s also the fact that you actually feel it, it’s the feeling”* (patient 5011).

### A3. Ability to see things from different perspectives and apply skills learnt

Five patients described increased flexibility in looking at things differently rather than holding rigid interpretations of events as they had done previously. In this regard they were subsequently more able to apply skills learnt and cope without turning to less helpful ways of coping. Specifically,

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<sup>2</sup> Traumatic incident that occurred in patient 5002’s past

patient narratives included reduced self-harm and suicidal behaviours, and increased motivation to gradually achieve one's goals. *"I've been hoarding for seven years... My house was a mess but I'm getting rid of all the stuff... Now I'm getting clothes out of bags, sorting everything out and clean... clothes that were just piled on the floor I bring them in I have a big rubbish bin with a bag in it and that's for Good Sammy's and that ones for rubbish, and that pile is to be hung up... this is what they teach you, just do it little steps... I have my little areas where they go and I'm getting there"* (patient 5011). Insight gained through ST has also allowed three patients to tune down the intensity of their emotional reactions toward themselves and others. *"I stopped turning anger towards myself which was good but still angry with other people. Where do we go from there, deal with anger in different ways... I exercise, play xbox and I enjoy doing different things, physical things help. I mentally talk to myself about things- I assure myself... A lot of reasoning 'It's okay, I'm not going to be here forever' if I'm really really pissed off, I would talk to my family I'd call and vent and they'll help me out and find a reasonable way to deal with issues"* (patient 5224).

#### A4. Change in confidence levels and assertiveness

Patients ( $n = 4$ ) described that ST improved their confidence levels in terms of being able to speak up for themselves and accomplish what they could not have before. Two indicated that the general increase in confidence levels appeared in various aspects of their lives including parenting, leaving the house to shop for groceries and meeting new people. *"You feel more confident... All of that stuff which I would never have considered before because one, I would*

*have to meet new people and that's too much anxiety, two, I have to regularly attend<sup>3</sup> it and I couldn't guarantee that I could sit through it too much anxiety and stuff I couldn't guarantee that I would make it. I didn't do that until probably the middle of the year cause' I finally felt up to it whereas I really couldn't have done it before really physically, emotionally couldn't cope with that"* (patient 5211). All four patients also articulated that rather than tolerating and making do with a situation that is distressing as they would in the past, they described being more able to assert their needs and stand up for themselves. Even though one of them dropped out of the study after 12 months of participation, she acknowledged that ST provided her the ability to do so. *"It's really kind of stupid, even funny but I don't think I could have quit for the reasons that I quit for without doing schema. I think if this has been anything else, I would have just sat there and made snarky remarks, and not engaged and not done anything. I would have finished the two years so I could say, 'Look, I finished it'. But I wouldn't have ever said, 'Hey. I've got a problem with this' or 'I'm not going to put myself in this situation anymore' ... It's weird in a way, it's like schema made me quit schema"* (patient 5033).

#### A5. Changes associated with feelings of fear

Patient narratives ( $n = 4$ ) reflected how ST has helped to reduce feelings of fear. Specifically three patients described being more accepting of and no longer fearing the vulnerable parts of themselves, accompanied by increased willingness to be vulnerable within the group and in therapy. *"I have no problem allowing my vulnerable child to be there and to discuss whatever and*

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<sup>3</sup> Parent group at a childcare where patient 5211's child attends

*allow myself to be vulnerable because I don't fear at all, there's no fear of being vulnerable within that group"* (patient 5002). Two of them also described some flexibility and openness in experimenting with asserting one's needs while feeling less worried and afraid that things would fall apart. *"I remember I had this fight with <sup>4</sup>XXX where I was like, 'You're not going to leave me just because we had a fight' So I'm going to be assertive and put my thoughts forward without having to do all the passive-aggressive stuff. And I just did it and I was like, 'Ok. The world didn't end. So that's a first. And you didn't leave me. So that's cool' and I actually got my point across for once"* (patient 5033).

#### A6. Extent to which ST minimised harshness to self

A third of patients ( $n = 4$ ) described feeling less harsh toward themselves particularly after gaining an understanding of where it stemmed from. They described regaining some sense of control *"That realisation that he can't really affect me that much, his emotions are his, instead of taking it as "I've done that, what have I done, it's my fault""* (patient 5025) as they were more able to separate from demands placed on them without perceiving that they were to blame for not fulfilling them. Not only did they feel closer to minimising or letting go of the harsh voice that they have internalised since childhood, one patient also mentioned that ST terminology provided a more "sensitive" language rather than one that is derogatory in nature. *"With schema therapy I named emotions with child names, adult, detached names. Before I'd be like 'shut up, don't be an idiot' I don't talk to myself like that anymore, no*

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<sup>4</sup> Patient 5033's partner

*more pulling yourself out of things in a negative way but in a more sensitive sort of way” (patient 5224).*

#### A7. Necessity of difficulty level in ST

Four patients found that while aspects of ST had been difficult, the process was necessary and helpful nevertheless. Patients used an array of descriptors to convey the difficulty of ST, which included “overwhelming”, “scary”, “painful”, “stressful”, “frustrating”, “uncomfortable”, “emotionally, psychological confronting”, “draining” and one patient described the process as sticking one’s hand in the hot oven. These challenging experiences generally involved the process of revisiting traumatic events that have happened in the past and getting to know their vulnerable selves and emotions. Patients also mentioned feeling this way particularly towards the beginning of ST (i.e. up to first 12 months of being in therapy) because they have been used to ignoring and detaching from these experiences. *“I did learn because I had always pushed down a lot of memories because they’re too painful for a child to remember. Schema helped to bring them out but I couldn’t have received treatment without acknowledging the existence of the trauma and I had to bring the trauma out on the table- to work on them” (patient 5224).* Additionally, two patients described ST as a long-term process that “retrains the brain” and therefore, it can be disappointing as results were not evident straightaway *“It’s a long time a long process and it’s no miracle cure but it does redirect your thoughts, explaining what schema’s about see I got it, I get it what it’s about I get that but some of them seem to think that it’s not working for them but it can’t work for them in 6 months- why is it a 2 year thing? Because it is*

*retraining the brain the schema modes... Some of them that left seem to think like 'Oh I don't know I was just rehashing up the past and that's not working and I'm not coming anymore' and they drop out"* (patient 5233).

### **3.1.2 B. Perceptions of ST as compared to previous therapies**

All patients compared and contrasted between ST and previous therapies; differences were identified across four themes as categorised below. Despite ST being harder for three patients, majority of patients ( $n = 10$ ) preferred ST and perceived it to be just as effective ( $n = 1$ ), if not more so than previous therapies. Only one patient described having a better therapeutic relationship with a previous therapist in individual therapy while another reported damaging consequences as a result of an abusive relationship with a previous therapist.

#### **B1. Degree of focus on internal processes**

Five patients identified that compared to previous therapies, ST goes deeper beyond one's thoughts into the possible reasons for one's unique way of thinking, feeling and behaving. Patients generally found the schema model more effective for individuals with extensive problems and not just specific to those with a borderline diagnosis. *"CBT it's so extremely basic CBT helps with mild problems but not for anybody with extensive health issues ... it didn't go deep, wasn't extensive as to how the mind works"* (patient 5224). While it was not explicitly stated that ST was harder than previous therapies, one patient discussed the utility of having previous therapy as a "lead up to schema". Three patients did however indicate that overall ST was more intense and in this sense, harder than previous therapies they had experienced. ST was also



described as working from the “inside-out” rather than “outside-in” and was therefore more confronting and scary, particularly having to revisit one’s traumatic events in childhood and being vulnerable within the group. <sup>5</sup>*It just seems to be really in your face like DBT has nothing on how confronting this can be- because <sup>6</sup>it’s working from the outside-inside out rather than outside in... It focuses a lot more like on your inside parts like rather than like with DBT you can calm yourself with like mindfulness or meditation and relaxation and all that stuff... You can kind of diffuse the situation whereas with schema it’s very different because it’s kind of like we’re being taught the opposite, not to do that stuff but to focus on why you’re doing what you’re doing rather than kind of ignoring with DBT... I mean <sup>7</sup>that does help but I’m just saying <sup>8</sup>this helped more but it’s a harder road to get to the point where it starts to help” (patient 5211).*

## B2. Acknowledgement/focus on the past

Four patients discussed how ST considered and dealt with past and traumatic experiences in childhood which were part of their experiences of previous therapies. While it may be unpleasant bringing one’s traumatic past to the forefront, it had been effective in helping one recognise the triggers to their emotions. *“Schema doesn’t just do the here-and-now but it also goes back to the past to deal with anything. Schema definitely helped, it’s never fun looking at problems in the past but it’s effective at doing that... the fact that you can identify where your emotions are coming from before they come and you can*

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<sup>5</sup> Schema Therapy (ST)

<sup>6</sup> Dialectical Behavioural Therapy (DBT)

<sup>7</sup> Dialectical Behavioural Therapy (DBT)

<sup>8</sup> Schema Therapy (ST)

*deal with them*” (patient 5224). Other patients also described its utility in recognising patterns in past behaviours and dealing with them in a different way. *“Schema therapy’s different cause’ it’s retraining your thoughts re-programming your brain to put it bluntly from childhood trauma and how you dealt with it then to how you can deal with it now”* (patient 5233).

### B3. Extent to which ST was prescriptive and tailored to individual needs

While previous therapies were seen as prescriptive and authoritative in encouraging patients to practise skills learnt in therapy ( $n = 3$ ), ST on the other hand provided more reasoning to the importance of practising these skills and explored the origins of one’s difficulties. In this sense, ST is not a “one size fits all” therapy and one patient explained that ST is “not a cookie cutter”. Instead ST was perceived to consider each person individually and was more tailored to the respective needs of each patient. *“DBT it’s like ‘This is what you do, do it!’ CBT’s sort of same. Mindfulness- it’s like ‘This is what you do, do it!’ and if you can’t, keep trying till you do it whereas schema therapy like even though in group, it’s kinda like ‘This is what you do’ but then you have your one-on-one sessions which kinda hashes out why you’re struggling with certain things or why you find things easier to do than others or why you can’t recognise certain modes but you can recognise other ones it’s really intense so I guess it’s not a cookie cutter it can be tailored to each person even if you’re doing the group”* (patient 5211).

### B4. Practicality of the provision/teaching of alternative ways of coping

ST was viewed as offering alternative ways of coping or dealing with one’s modes and triggers ( $n = 3$ ) while affording patients the space and

opportunity to learn skills during times of distress during therapy, which were more similar and replicable in real-life crisis situations. One patient expressed difficulties with remembering skills taught in previous therapies when faced with an actual crisis situation. This is particularly because previous therapy settings were largely intolerant of distress or crises that occurred in therapy and in this sense, ST was perceived as more realistic and therefore skills learnt in ST had a higher likelihood of being applied when faced with an actual situation. *“I found with the DBT, it was, “We are going to try and keep you all very calm so you can learn as much as possible. We don’t want to upset anyone. We don’t want to set anyone off so that you can learn stuff.” Whereas in schema I was kind of like, “Oh, if this actually sets you off, good. We’ll have an opportunity to practise now” (patient 5033). In addition two of them indicated applying techniques learnt in previous therapies, which they have never before implemented. This shift was due to ST providing understanding and reasoning behind each teaching rather than merely prescribing what to do with no further explanation. “<sup>9</sup>It’d be like, ‘Do this’ and I’d be like, ‘Why? How? Tell me exactly how it will help and what it will do’ and they’d be like, ‘Trust us, it helps’. That pretty much sums up most of my therapy experience. Whereas with the schema, it was like, ‘This is how it works. Here’s what you should do’... and it’s like- ‘Oh, it does this. And this does this’... I remember doing things like affirmations in CBT and they’d be like, ‘Do affirmations, write things on pieces of paper and repeat it. Put it on your mirror so every time you see it, you write it’. Now because I’ve done a s\*\*\*load of neurological research, I know what that does and if they told me, ‘Do affirmations because it*

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<sup>9</sup> Patient 5033’s previous therapy

*increases the gaps between neurons...’ I would have been like, ‘Cool. I’ll do affirmations’. But then it was just like, ‘Do affirmations’, ‘Why?’ ‘Because it works’” (patient 5033).*

### **3.1.3 C. Expectations, Feelings and Beliefs prior to and after starting ST**

The majority of patients ( $n = 8$ ) expressed having some expectations and feelings about ST before therapy started. Five patients commented on their experience of ST being inconsistent with their initial beliefs with four describing how ST surpassed their expectations while one felt that ST had fallen short of expectations. It was observed that all three patients who endorsed having low expectations at the beginning subsequently reported ST exceeding their expectations whereas the one who described feeling disappointed started off feeling hopeful.

#### **C1. Indications/attitudes of hope and openness**

Five patients described feeling hopeful ( $n = 4$ ) and excited ( $n = 1$ ) before starting ST. Patients expressed feeling hopeful to some extent primarily based on what they heard of or read about regarding ST having high success rates. Two patients also described not having prior expectations due to disappointment and bad experience from previous therapies yet were open to trying but hoping that ST to turn out otherwise. *“I wanted to give it a shot, because I’d heard all that stuff about how good it was. I didn’t think it would be as good as they said, but I was willing to give anything a shot at that point. I went into it with no expectations, just hope. I’ve been let down by other treatments, so I came in going, if it works, it works, if it doesn’t, it doesn’t”* (patient 5211). Conversely, another patient reported feeling excited because her

previous therapy experience had been “life-changing” and she was interested to find out how much more she could gain from ST. *“I was a little excited, because if DBT could change my life that much, how much is it going to change when I walk away at the end of this? I had that excitement, but I did not know”* (patient 5025).

## C2. Expectation levels

Four patients discussed their expectations levels prior to starting the schema study; one patient expressed indifference to the outcome of ST while three patients described having low expectations, two of whom attributed that to the ineffectiveness of previous therapies. One of them went into ST without having much hope and further described ST as her last shot at therapy. *“All the stuff that I’ve been doing hasn’t worked. So if schema works, then good. But if I put the two years into it and it doesn’t work... at that point I would just be like, Ok. I’m going to be like this forever. I won’t try anymore”* (patient 5033).

Another patient expressed concerns specifically about the group component of ST due to the expectation that the presence of others might be upsetting. *“I didn’t want to be in the group. I said to <sup>10</sup>XXX- ‘It’s going to upset me just walking in there because there’s other women and people in there’, and he says ‘But you’ll all get to know each other and realise how close you can be’. I said ‘XXX I’m telling you now I won’t stay’”* (patient 5011).

## C3. Extent to which ST surpassed expectations

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<sup>10</sup> Patient 5011’s previous individual therapist

Several patients ( $n = 4$ ) described that ST had exceeded their expectations, including the same three patients who initially endorsed low expectations. They described feeling pleasantly surprised with the benefits gained as a result of ST. *“I know I’ve got more out of it than I expected. But I think I’ve actually got more out of it than my case manager expected, as well”* (patient 5033). Two patients also indicated that ST was not as hard as they had originally expected. For example, the patient who initially expressed strong reluctance in joining the group found that as group sessions progressed, it developed to a reluctance of having to miss a session. *“I was so against it, I hate groups but it just sort of brought us together with the same problem and it was like we can all sort this out, we can do this in this group and for a while there I hated going and now- I hate missing it... Sometimes now it can be quarter past twelve, we need to leave at noon... And quarter past twelve we’re still in depth and talking- and we don’t want to leave”* (patient 5011).

### **3.2 Part Two: Group and Individual components of Schema Therapy**

Themes emerging from analyses of patients’ accounts of the significance of specific group and individual components of ST were summarised into three topic areas, as presented below in Table 5. Namely, patients’ A) Group experiences and dynamics, B) Structure and format of group and individual ST, and C) Relationships with group and individual therapists.

Table 5

*Group and Individual components of Schema Therapy*

Topic/Category	Themes/Subcategories	n
A. Group experiences and dynamics	Sense of connection among group members	9
	Feelings that arose when comparing oneself against others	7
	Level of difficulty in expressing/dealing with emotions	7
	Level of friendships formed within the group	7
	Group members providing different perspectives	6
	Extent to which one felt safe, accepted and able to trust others in the group	6
	Group factors contributing to comfort levels in opening up/pulling back	4
	Perception of attention received during group sessions	4
B. Structure and format of group and individual therapy	The use of experiential techniques	7
	The use of schema-mode model	6
	Utility of breaks/light activities and props available	5
	Extent to which group and individual ST complemented each other	5
	Flexibility of session structure	4
	Degree to which a decrease in the frequency of group sessions can be disruptive	4
	Duration/length of therapy sessions	3
C. Relationship with group and individual therapists	Extent to which individual therapist was skilful and supportive	8
	Extent to which group therapists were supportive, attuned and skilful	6
	Differential feelings toward co-therapists	4

### 3.2.1 A. Group experience and dynamics among group members

All patients discussed and frequently referred to their experience of the group. Eight themes emerged regarding their perceptions of the group in general together with their experiences as a group member. The terms “comradeship”, “chain-link” and “unit” have been used to describe the group in the Group ST condition. Aspects that were rated positively included the sharing of similar experiences and group members contributing ideas and solutions, friendships formed and the use of humour, together with feelings of safety and trust within the group. Apart from the initial discomfort patients experienced when they first began group ST, other negative group experiences included feeling left out, feeling frustrated when comparing against others who were progressing and the perception of not receiving enough attention. There were also three patients who felt distrustful and unsafe to fully express themselves after unpleasant incidents occurred during group.

#### A1. Sense of connection among group members

Nine patients discussed the sense of connection among group members; more than half of the patients ( $n = 6$ ) believed that the group component helped facilitate a sense of connection with like-minded individuals who faced similar issues in life while a minority ( $n = 3$ ) described feelings of exclusion and had a “hard time fitting in”. On one hand being in the company of similar others was generally described as a positive experience, particularly for two patients who viewed themselves as isolated individuals using terms including “*socially awkward*” (patient 5216) and “*loner*” (patient 5233). The group setting allowed patients to develop a bond among themselves and the understanding



that they were not the only ones with such difficulties. *“When you’re in a group and they’re all going through the same issues it’s like ‘I’m not the only one’... Because some of them are in their twenties, some in their thirties, one in their forties, I’m in my fifties, and to hear that they’re going through that same thing... and a lot of their experiences are- have been just about identical to mine and it’s like ‘Wow, it’s amazing’, actually the way we think also is very much alike”* (patient 5011). Two patients also commended the laughter shared during group sessions facilitated the bond among group members. *“The sense of humour in the group is great. Apparently, we’re really, really loud. Everyone in here can hear us... There was a guy up front who picked up the water bottle, threw it through a wall and there was a doctor, going, ‘Ah, that’s just the schema group’ because it was so loud. I think the sense of humour really helps”* (patient 5025). On the other hand, three patients believed that they had “nothing in common” with other group members due to being in different stages of life or being involved in completely different activities outside of group. One of them described being on the “outside” and did not feel understood by others. *“No one else works if you get what I mean so it’s like no one else can understand that I’ve got other stuff coming on going on outside... I’m comfortable as part of the group but I tend to detach a lot and sometimes I feel as though I’m outside looking in you know yeah...I had a lot of stuff going on at work and when people don’t work they will kinda say “well just give up your job” you know they just don’t understand”* (patient 5221).

A2. Feelings that arose when comparing oneself against others

Patient narratives ( $n = 7$ ) included a mixture of feelings including those of frustration, irritation and comfort when comparing oneself against others in the group. In particular three patients described feeling annoyed at themselves for not progressing or picking things up as fast as the others however they were able to identify that they were being punitive towards themselves. *“Especially if someone in the group has a revelation before you do, and they come in going, ‘Guess what! I recognized my trigger and I managed to stop it!’ You think, why can't I do that? As much as you feel happy for them, you kind of feel down on yourself. That's also old coping mechanisms, if you're a very punitive person”* (patient 5211). Another patient described the perception that these group members came across as insincere and disingenuous in the positive experiences they shared *“Sometimes I don't know whether people are progressing and I'm not, or whether a couple of them it's like ‘fake it till you make it’... She was saying she's come so far- she was exceedingly talkative in group and everything was extremely positive and everyone's like ‘Oh you have grown, this is great’ you know but I picked up an element of fake kinda thing, it was very melodramatic”* (patient 5221). Conversely three patients indicated that when group members shared or disclosed negative experiences and their struggles, it provided some sense of comfort, making it easier to share their own experiences and enabled one to notice progress made. *“I can recognise in things that people are describing or the way they act and that would have been me 5 years ago but I'm not there anymore. And as awful as that sounds that you look at someone who is not doing well and that makes you feel better about yourself and that's also enabled me to see how far I've come”* (patient 5206).

A3. Level of difficulty in expressing/dealing with emotions

The majority of patients ( $n = 7$ ) expressed discomfort in revealing and dealing with intense emotions within the group. All seven patients mentioned that it was daunting at the beginning of therapy to share their emotions particularly when they felt unfamiliar among other group members. *“Not in the beginning. I felt so much shame for my own personal things, I didn't want to share. Just before I went to group, I had reported <sup>11</sup>XXX that happened to me. It'll be eight years ago now- But I couldn't even say it. I couldn't even...I still can't... that's really difficult for me”* (patient 5025). One patient described discomfort in dealing with her own emotions that were triggered from content shared by group members. *“At times it's been a battle, but only because at some point...I realised again through schema that it wasn't the person that I was angry at, it was what they were triggering in me- I get to that- ‘What the f\*\*\* why don't you just shut up’ ... I get that sort of feeling, and I suppose I come across as being little bit angry or I get a little bit aggressive with my attitude...I haven't like nasty like say ‘F\*\*\* off’ or whatever to somebody but at the same time I think there's been times where I've probably been intimidating where I've just like ‘Leave me alone!’”* (patient 5002).

#### A4. Level of friendships formed within the group

Seven patients discussed the level of friendships made with group members. Apart from one patient in the Group ST condition who discontinued after 12 months of therapy, the remaining four patients described close friendships made and would often meet with one another outside of group.

*“I've got a close friend from here... she and I, we're really close... probably*

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<sup>11</sup> Traumatic incident in the past

*see each other... at least four, five days we'll see each other for- even if it's just for coffee" (patient 5002). Even though patients in the Combination group did not have meet-ups outside of group, one patient described group members as "friends" and would communicate with some via Facebook. "I like the people in my group they're my friends... we tried to but everyone's got different schedules, we talk on Facebook... I don't usually talk to people on Facebook but it's alright" (patient 5216). Two other patients in the Combination condition reported being against being friends outside of group. They described being different from the rest of the group and one of them mentioned not wanting to be around individuals with a borderline diagnosis particularly after therapy has concluded, as that may have an adverse impact on others. "I'm very much a realist I mean in May or March or April or whenever it's going to end then it's time to put it into practice- I don't want to see these people again on a friendship basis... because reality is I wanna mix with people that don't have a borderline diagnosis... It's a bit like when you end up admitted to hospital... even though you're kind of support each other in hospital you don't end up friends outside of hospital... When someone's not running too well and if you're both not running too well it can impact each other so I don't wanna bring anyone else down" (patient 5221).*

#### A5. Group members providing different perspectives

Six patients felt that being a part of group activities; contributing and listening to alternative perspectives and hearing how group members handled some of their issues were helpful. The sharing of ideas generally led to patients feeling closer to one another and provided "that caring sort of atmosphere", in

that group members were interested in what one another had to say. *“When you’re in the group after a while you get close to the people and when something bad happens there everybody cares about that and try and help... I don't know I felt like they cared for me, it was good, that I mattered I guess, that I was important”* (patient 5216). It also provided constructive feedback that patients can consider to better the situation in future. *“When we speak there’s usually a part when everyone gets asked how they felt about that and what they thought could have been done better and stuff like that which is good because you get everyone’s input on how they would try to better it and stuff like that... I like the group I think it helps a lot... I like to hear about how other people have fixed their problems and how they’ve done stuff it helps”* (patient 5216). Two patients described that being involved in a group activity or helping group members solve their problems have incidentally helped them gain learning points for themselves. *“It was healthy because through group I was able to- I suppose nurture her but realize that I was actually taking that on board for myself for the first time”* (patient 5002). In addition, patients commented that contributing as a member of the group was more powerful than when group facilitators did. *“Me being another member in group when I was saying these things it affected them and they were struggling a bit. The facilitators are just doing their job. As someone in group, it is more powerful than someone who receives the pay cheque and they are obliged to do whatever so what they’re saying what they have to say”* (patient 5224).

A6. Extent to which one felt safe, accepted and able to trust others in the group

Feelings of safety within the group and trust among group members were salient for six patients. Four of them described being able to completely trust group members and felt safe enough to be vulnerable in front of them, however one of whom also indicated that this does not extend to outside of the group context. *“Within the group setting I trust them all implicitly with my vulnerable child. I have no problem allowing my vulnerable child to be there and to discuss whatever and allow myself to be vulnerable because I don’t fear at all... I trust them. Would I allow myself to be completely vulnerable on the outside of the group...in different ways only because of how far that person is involved in my life”* (patient 5002). On the other hand two patients in the Combination ST condition felt unsafe among group members and expressed reluctance to share parts of themselves to the group. One of them attributed such feelings to the resemblance of group members to her past. *“You cant put 8 people together and force them to be close and in my experience there’s been people in the group that I don’t feel safe with so I won’t become close to those people, those people represent my past so I wouldn’t be drawn to people like that”* (patient 5230). It is important to note that these feelings appeared to surface due to relationship ruptures following an incident that occurred during group between both of them.

#### A7. Group factors contributing to comfort levels in opening up/pulling back

Four patients indicated certain group factors that led to them opening up ( $n = 1$ ) and pulling back ( $n = 3$ ) during group. One patient described how similar experiences shared by group members had facilitated self-disclosure. *“Once the girls started sort of sharing and I’d sit there and go ‘Oh...’ I*

*probably would talk now because that is something identical to what happened to me and I reacted identical what she did and I'm like 'oh yea' and then we realize we are all just the same really just trying to get by"* (patient 5011).

Another three patients felt unsafe to express how they truly felt during group after one or more incidents. They had initially expressed their honest opinions regarding certain issues but received negative responses from a few members of the group, leading to them not contributing as much as before. They mentioned that trust had been lost and they felt the need to withhold their opinions for fear of triggering intense emotional responses in others. *"I've been on the end of one of these people's particular outbursts anger twice... so I've learnt to shut up- they can lose control quite easily and it's definitely not safe for me... You can't talk to these people about it you can't say, 'Well you need to shut up more and let other people talk' because I mean you'd get your head ripped off, you would"* (patient 5230).

#### A8. Perception of attention received during group sessions

Four patients discussed their experiences when group members dominate the session. They felt "neglected" and expressed irritation and impatience particularly when the content shared came across as irrelevant to them and when it was "hard to get a word in". They felt that too much time have been spent on these group members and one patient described "switching off" when they "take over". *"There's two members particularly that take over once they come in to the group, that's it, it's all about them and so you just sit back try and switch off cause' you don't want to listen to it... Because their emotions are running quite high so you just sit there switch off shut up because*

*these two particular people have problems keeping it together” (patient 5230).*

In addition, two other patients felt the need to be overtly upset and distressed to receive sufficient attention in the group. *“If you get really upset, we’ll pay attention to you. But if you are already a little bit upset, if you are not upset enough to show it, then ‘I’ve got my own s\*\*\*, you deal with that’” (patient 5033).*

### **3.2.2 B. Structure and Format of Group and Individual ST**

The majority of patients ( $n = 9$ ) commented on the structure and format of schema therapy. While some patients described the tapering of group and individual sessions as disruptive and were dissatisfied with the duration of the ST model, others found experiential techniques applied, the use of the schema mode model, flexible session agenda and activities conducted during group useful.

#### **B1. The use of experiential techniques**

Seven patients discussed the use of experiential techniques; all but one appreciated the use of imagery rescripting, visualisation exercises and role-plays. The provision of therapy concepts experientially was generally perceived as more effective than discussing them verbally contributing to a deeper level understanding. Despite some initial reluctance from some patients, they described being pleasantly surprised with the outcomes and these exercises were the “stand outs” in therapy. *“There’s one group that stands out to me... We were sitting like we were in a car and each person was a schema or a mode and the therapist was the healthy adult or the healthy parent... You could see the schemas in action and how they’re not helpful and how and why you do*



*that... I think I was the punitive parent and then I was a vulnerable child and I could see the difference, I could see how they all interact with yourself or myself and life and other people... It stands out in because you don't get it intellectually you feel it, it's like a lightbulb moment it's like a 'Yupp' you really get how if you were in that mode how difficult for positive messages to come through and- actions speak louder than words" (patient 5230). However one patient described imagery rescripting as "airy fairy" because of the unlikelihood that the outcome of an event would be altered. "They do like a rescripting thing where you go back and you look at something that happened in your childhood and look at how it could have ended then and I kinda think that that's not how it ended- I sort of feel like no matter how many times someone tells me it could have ended a different way I still know it ended that way so- I feel it's a bit airy fairy... I'm sort of more logical and practical person so to me that doesn't make any sense" (patient 5206).*

## B2. The use of schema-mode model

In addition to overall utility of experiential techniques six patients brought up the use of schema-related content (e.g. schema modes) and terminology (e.g. punitive parent). They generally discussed the usefulness of psychoeducation and while two patients initially found the schema terminology "confusing" (patient 5002) and "difficult to grasp"; one of them subsequently found the concepts helpful in categorising and making sense of various events/situations. "Originally, the modes I found really, really difficult to grasp. But once I did, it was a lot easier to categorise everything... it would be like, 'Ok, this happened. Here's the category that fits in, here's the things that

*have led to that category before, here's the things that you can do to negate that category". Because I'm really analytical, I found it a lot easier to sort of put things in boxes and have like a linear pathway of this. And the models that we did- like would become flowcharts and I liked that and I was like, 'Oh, I can see how that all fits together'" (patient 5033).*

### B3. Utility of breaks/light activities and props available

Light activities/breaks (e.g. games) and props (e.g. blankets) used during GST have been described as “fun” and “excellent” by five patients. Three patients commented on the necessity of breaks in between heavy discussions to provide some space to process content covered and lighten the mood. *“We always have a break in the middle of the hour and a half... I think that's good because- 45 minutes to an hour is anyone's concentration span so the fact that that's recognised I think that's made a difference because I think if<sup>12</sup>they didn't do that we wouldn't get as much out of the group, and also- it's very intense, once we sort of finished with that, then we sort of maybe play a game for a few minutes- that have nothing to do with schema they just sort of lighten the mood and then we sort of go on to the next topic- that makes a really big difference in the groups too rather than just keep plugging on with the intense stuff”* (patient 5206). Additionally two patients found the blankets and pillows helpful in providing a sense of comfort and safety, together with some form of distraction and grounding. *“They say 'Look we've got blankets and pillows, you can cuddle them and hug them if you want and we've got feather boas you can just be silly with it if you want', they are trying to get us to feel*

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<sup>12</sup> Group schema therapists

*tactile and things and be in the moment... We are not very mindful of where we are, and we have to be mindful- which is good, that's excellent... I had no idea of all this and it's just amazing" (patient 5011).*

#### B4. Extent to which group and individual ST complemented each other

Five patients discussed the necessity of having a combination of group and individual ST, explaining how each was different but equally important and how they complemented each other. Patients found the group component useful in learning schema-related concepts, various coping skills and providing the opportunity for interaction with others. It also helped build patients' confidence by practising these skills within a safe environment before generalising them to the community outside of therapy. *"Honestly for schema, I believe you need a combination of both, you really do because... If you've got it individually- you've just got you and that one person so you're not really putting it to any sort of test... You're not flexing yourself... You can sit there and just do the one-on-one stuff but if you do one-on-one plus group then there's that trial, there's that testing the waters and- you're also in a place of 'It's okay' because you've got your therapist and you've got these other people- it's safer... you've got more confidence to then go outside the doors and be confident outside in that community" (patient 5002).* On the other hand patients felt that group therapy can at times remove the attention off each patient whereas there is room in individual therapy to pay full attention to patients. One patient described the utility of individual ST in not only allowing further discussions of topics or particular schema modes that stood out during group ST, but also providing them undivided attention and a private space to explore one's unique past on a

more personal level. *“In group, it focuses on learning the stuff that you need in order to get better, and one-on-one is more focusing on you, and why you need this stuff in the first place... In order to learn the things that you're learning in group, in order to utilize them, you need to have the one-on-one in order to work through all that past stuff”* (patient 5211). Another two patients mentioned that the space in individual ST sessions added value to group ST in permitting further discussion of topics raised during group they found particularly relevant/interesting and in ventilating conflicts occurring during the group. In this sense they need not worry about offending other group members by bringing up potentially sensitive topics within the group. *“I mean also problems in the group because there has been problems in the group, and I'll talk to <sup>13</sup>her and she says well that's all right we'll look into that, that's not a problem... and it's good because we don't have anyone to speak to about the group”* (patient 5011).

#### B5. Flexibility of session structure

With regards to content covered during group ST, four patients described the flexibility of group ST in allowing for deviations from the session agenda. While patients mentioned there was a general guideline with which group facilitators set out to cover during group therapy, group facilitators were permissive in exploring issues brought up by patients and patients described being able to bring up subject matters that were important to them at various points during group regardless of whether or not they were part of the plan.

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<sup>13</sup> Patient 5011's individual schema therapist

*“Well I think normally <sup>14</sup>(XXX and YYY) have a plan for what’s going to happen but... it also depends on what’s going on with people so someone might come in and something might have happened during the week and they’ll say ‘Can we talk about this’ and so then it will kind of other people will give similar experiences or that becomes the focus and they’re very good at letting that happen rather than stopping and going back to the agenda. They will just let that flow and then when it comes to a halt where everyone’s finished- then they will- look at their timetable or whatever” (patient 5206). In addition to that, two patients described how the schema model was applied or integrated with what group members chose to share with the group. *“They also allow to divert, but at the same time they could hook that back through into like a schema sort of mode- they’d utilize that to show a different mode or to show this that they were trying to point out at the same time” (patient 5002).**

B6. Degree to which a decrease in the frequency of group sessions can be disruptive

Four patients regarded the tapering of group sessions as disrupting connections among group members. Patients generally described missing group members, as they felt attached to one another through sharing of personal information and it can be difficult to “get the connection back”. *“Because It’s once a month and you miss them because you started to be quite attached to seeing them the group- I mean you do release a lot of information to each person what you’ve been going through and you do become quite bonded as a group and you worry about them- if someone hasn’t turn up or if someone quits*

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<sup>14</sup> Group therapists in the Combination ST condition

*or you know you do feel that pain for them or whatever” (patient 5211).*

Another patient mentioned that the transitions from fortnightly to monthly were “too quick” particularly in individual therapy and felt ill-equipped in terms of dealing with those transitions. *“Going from monthly to fortnightly you kind of just - it took me a while to get from weekly to fortnightly and then just as I’m getting into fortnightly it goes to monthly and for me personally I think it’s too quick- I mean we all knew it’s going to happen- but the impact on me has been so hard because for me it has really thrown me into the mistrust the abandonment and my whole life has been focused on that and- you’re not given any skills to learn on how to deal with that transition” (patient 5230).*

#### B7. Duration/length of therapy sessions

Three patients expressed dissatisfaction regarding the length of schema therapy; they described the two-year duration as insufficient and felt fearful and worried about finishing up. *“I am nervous that it’s finishing, because I think I need longer. I think some things should’ve been brought up a bit earlier but then again, it’s building on trust. It’s hard... I’m a bit fearful of when it finishes- that feeling of being completely alone” (patient 5025).* One of them added it was increasingly difficult particularly because she felt she had not made enough progress before the therapy concluded and became more “detached” towards the end of therapy. *“I’m probably more detached in the last 6 months than ever in the whole of schema- and it’s because of the whole monthly thing and it’s because they say ‘Oh you know schema is finished in 6 months’ but the reality of it is schema is finished in six hours and they’re like ‘you know things are going to change’ and it’s like- ‘In six hours? Six hours you’re going to take 40*

*odd years and change it in six hours, are you?’ it’s not going to happen... So I feel like I failed” (patient 5230).*

### **3.2.3 C. Relationship with group and individual therapists**

Ten patients discussed issues regarding the relationship with their group and individual therapists. Six patients spoke of positive qualities of group therapists and described positive feelings toward them. While three patients held differential attitudes toward each group therapist in the Combination condition, another patient reported feeling awkward as a result of the unequal dynamic between them. Of the eight patients who commented on the relationship with their individual therapists, six described a good fit and positive therapeutic relationship, while two expressed frustration and dislike.

#### **C1. Extent to which individual therapist was skilful and supportive**

Patients’ perceptions of and relationships with their respective individual therapists were discussed ( $n = 8$ ). On one hand six patients used a range of positive adjectives including “brilliant”, “clever”, “perfect”, “amazing”, “supportive” and “attuned” to describe their respective individual therapists. There was a good fit between them and their individual therapists and one patient elaborated that she felt emotionally connected to and appropriately supported by her individual therapist throughout. *“She’s been brilliant, she really has! I couldn’t have asked for anyone better, I mean she never once tried to do anything for me, she only directed me which was great. She was the perfect person I needed, she really was!”* (patient 5002). Another patient mentioned that while her individual therapist has at times been “hard” on her, it had also been a supportive experience. *“My individual therapist is*

*very hard but- I think she's very clever, she doesn't let me get away with much... I would say, she makes me face things and she's quite supportive as well"* (patient 5221). On the other hand two patients expressed dissatisfaction and feelings of frustration towards their individual therapists. They experienced the therapeutic relationship as unhelpful; they felt misunderstood, as they perceived their individual therapists to "jump to conclusions", misinterpret what was said and impose their own ideas. One of them also discussed a lack of connection in terms of life experiences and not being "on the same page" in their views. *"What I was finding particularly hard with my individual therapist is she doesn't have children... I have a very close relationship with my children- they're the most important people in my life I have a lot to do with them still... She's sort of been almost trying to imply that that is a detriment? She was making an assumption on what she thought was wrong with that and what needed to be fixed- but that's not necessarily what I think is wrong or needs to be fixed"* (patient 5206).

## C2. Extent to which group therapists were supportive, attuned and skilful

Six patients found group therapists generally supportive and helpful, both during and outside of group therapy sessions and described them as non-imposing and non-judgmental in their views, permitting them to freely speak their minds without feeling restricted in their questions or comments. Group therapists were being described as attuned to whatever is happening within the group and in this sense created a sense of safety. *"They're onto you. Even if I well up with tears and I don't actually drop one, I'm already noticed. If I shift in a chair, they know that I'm in pain. They notice what everyone's going through.*



*One of them could be talking, but the other one's keeping an eye on you. Again, that brings a safe feeling in” (patient 5025). Two patients brought up the issue of therapist self-disclosure. One patient described the increased level of closeness she got to know more about the group therapist’s life outside of therapy. “Even the counselors talk about their kids and grandkids and when they say- ‘my boy was so old and he did this’ and we go ‘really’, they say ‘Yes I’m a counselor I’ve just done the training that doesn’t mean that I don’t have a life like yours girls!’ And that also brings us all closer because we know all their kids names, you sort of get to know their life and it makes you all feel as one” (patient 5011). Conversely another patient in the other treatment condition characterised the therapeutic relationship as impersonal and one of “indifference” and while group therapists were seen as “supportive”, she did not feel supported. “I suppose indifferent, I don’t know anything about them... I mean they are supportive and I have spoken one-on-one to them but they just are people I don’t know anything about them... Put it this way, if I was distressed or anything, they wouldn’t be the people that I would run to” (patient 5230).*

### C3. Differential feelings toward co-therapists

Slightly over half the patients ( $n = 4$ ) in the Combination ST condition held differential attitudes toward the co-therapists with three patients speaking positively of one group therapist but not the other. They experienced one as understanding, skilful and accepting while perceiving the other as “inappropriate” and at times “judgmental” and “making assumptions” about

others. *“They always pay attention. <sup>15</sup>XXX is very good very involved happy kept us all interested and attuned to what we have to say. She is the best one that understands. And <sup>16</sup>YYY not too much... She seemed detached, rude and blatant... She’d say things like ‘you’re not paying attention’ it’s been a long time but she’s annoyed me and upset others in the group. I don’t think that’s the place she should be... It’s almost like a good cop bad cop”* (patient 5224).

Another patient who, without directly addressing attitudes toward group therapists, felt “so awkward” as a result of group therapists having an unequal dynamic during group sessions. *“You can see one dominates over the other but it’s like you never know it’s a bit awkward ... I feel so awkward it’s like ‘oh no’, one’s trying to talk but the other one’s not letting her cause’ she’s obviously the boss... At the start they were like fighting over who’s more important... I could see it myself- one would try and lead the group and then the other one would start doing it over the top”* (patient 5216).

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<sup>15</sup> Group therapist 1 in the Combination ST condition

<sup>16</sup> Group therapist 2 in the Combination ST condition

### **Chapter Four: Discussion – Patient Participants**

The purpose of this study was in part to understand and describe BPD patients' experiences of receiving schema therapy. Reported gains made by patients with BPD following the two-year-long schema therapy program included increased insight, better connection with one's emotions, improved self-confidence, greater self-acceptance, reduced feelings of fear, increased cognitive flexibility in terms of taking alternative perspectives and making behavioural changes by applying skills learnt.

These reported benefits gained from ST lend support to previous quantitative studies where ST was found to lead to improved therapy outcomes such as better quality of life, reduced BPD symptomatology and positive changes on maladaptive schemas (Farrell et al., 2009; Giesen-Bloo et al., 2006; Nordahl & Nysæter, 2005). However, quantitative studies tended to have predetermined criteria of what recovery from BPD means when in fact recovery is a highly personal phenomenon. While patients' definitions of recovery have not been directly explored in this study, aforementioned improvements made were consistent with various representations of recovery from BPD found in Katsakou et al. (2012). Based on interviews conducted with 48 service users diagnosed with BPD who underwent psychological intervention (e.g. cognitive behavioural therapies, psychodynamic approaches), subjective interpretations of recovery reflected enhanced confidence and the value of self-understanding or making sense of the origins of one's difficulties. This would subsequently help reduce self-blame and facilitate acceptance of the self (Katsakou et al.). The necessity of gaining insight and self-understanding was almost unanimous among patients in the study. Through acknowledging one's past experiences

and developing self-understanding, ST has helped minimise harshness to and facilitated acceptance of the self.

The importance of insight was also supported in previous studies (Araminta, 2000; Hoffart et al., 2002). A qualitative study that explored both therapists' and BPD clients' perspectives of DBT clients reported the value of self-awareness regarding the etiology of BPD and reasons for their behaviours (Araminta). Even though increasing self-awareness was not a prescribed focus in DBT, client reports in Araminta provided support for the importance of insight and self-understanding found in the current study. In particular insight achieved during the early phases of schema therapy (i.e. first three sessions) was found to be significantly associated with weaker schema belief and emotional distress (Hoffart et al.).

Patients' perceptions reflecting increased connections with and ability to verbally express one's emotions were in line with therapeutic aims outlined in experiential therapies. For example, developing emotional awareness was described as the first goal in emotion-focused therapy in overcoming emotional- arousal and processing (Greenberg & Safran, 1987) while integrating and making sense of one's experiences (Greenberg, 2004). Because the basic need of expressing or having emotions is often unmet in childhood for individuals with BPD, Kellogg and Young (2006) encouraged experiencing and the subsequent expressing of feelings as a stepping-stone for therapeutic change (e.g. reducing maladaptive ways of coping). Results from the current study relating to patients' ability to recognise and verbalise their emotions also attested to the success of achieving aims set out in ST.

Patients' enhanced ability to look at things from different perspectives and having a quieter or almost vanished internalised punitive voice were consistent with cognitive flexibility frequently referred to in the cognitive literature as the ability to adjust and restructure one's unhelpful thought processes (Dennis & Vander Wal, 2010). Other improvements made including reduced feelings of fear, enhanced confidence levels, assertiveness and ability to apply skills learnt were manifested in patients' efforts to reality-test and make behavioural changes (e.g. asserted one's point of view without fearing what the other would do). These changes while subtle certainly represent defining behaviours and act as building blocks to achieve lasting changes.

The similarity between reduced feelings of fear and increased connections with emotions reported by patients was a greater acceptance/tolerance of the vulnerable parts of themselves, and the increased willingness to share this vulnerability with people they trust (e.g. group members). In a study that investigated the components of wholehearted living, Brown (2012) found vulnerability to be essential and argued for the need to embrace vulnerability as a precursor to leading a fulfilling life. Taken together not only do they provide support to the aim of working with the vulnerable child mode outlined in the ST model (Young et al., 2003) but also implied the importance of getting in touch with and integrating different parts of the self that may have been pushed aside.

Most patients found ST more effective than previous therapies albeit difficult primarily due to the depth and level of understanding with which ST works through as well as its consideration of one's past experiences and uniqueness of individual needs. These themes signify a therapy experience that

extends beyond the circumscribed focus on borderline symptoms to consider factors that contribute to one's personality structure and sense of self. An overemphasis on treating borderline symptoms can inadvertently overlook and ignore the existence and extent of past abuse. Symptoms that characterise the borderline diagnosis have often been referred to as a consequence of the disorder rather than an attempt to maintain some sense of personal integrity in response to trauma (Shaw & Proctor, 2005; Warner & Wilkins, 2003). Current findings that relate to the necessity of rehashing certain distressing life events and the negatively-laden emotions that accompany despite its difficulty clearly indicated the importance of processing such memories; lest they remain unprocessed or raw creating other problematic issues that can persist in one's life. That is to say, treatment that solely focuses on eliminating symptoms may not only run the risk of denying the context with which one's distress developed, but also over-pathologising adaptive reactions to valid psychosocial stressors. This creates or reinforces the idea that there is something wrong with the individual or that one is "defective", which is counterproductive to weakening one's maladaptive schemas in ST.

Current results reflected that difficulties faced during ST were largely confined to the initial 12 months and ST had in the long run enabled patients to make progress in many areas of their lives. Additionally present findings of patients' expectations were found to be dependent on previous therapy experiences; the more highly past therapy approaches were rated, the higher the expectations for ST to be effective and vice versa. Present findings also indicate a directly proportional relationship between one's expectations prior to and one's level of disappointment after starting ST. Overall patient narratives

revealed that retrospectively, ST had exceeded prior expectations in terms of the benefits gained and positive changes made in one's cognitions and behaviours.

#### **4.1 Therapeutic Gains attributed to Components of the Schema Model**

Components within the schema model identified in facilitating positive outcomes achieved by patients included the use of experiential techniques, learning of schema-related concepts (e.g. schema modes), flexibility of session structure, therapeutic relationships and the combination of group and individual ST.

Current findings generally revealed the value and effectiveness of experiential techniques (i.e. imagery rescripting, visualisation exercises and role-plays) particularly in enhancing one's understanding of therapy-related concepts (e.g. schema modes) and content (e.g. perspective-taking) while increasing awareness of and connections with one's emotions. These findings were consistent with the aim of using such techniques in ST to create therapeutic change (Young et al., 2003). Such experiential exercises serve as an agent in facilitating one's capacity to take alternative perspectives by directly placing patients in a different role and in this sense creating opportunity for them to access and experience various emotions. An empirical study investigated the steps involved in emotional processing during emotion-focused therapy with individuals who were depressed or currently experiencing interpersonal problems (Pascual-Leone & Greenberg, 2007). Through video analyses of therapy sessions, sessions that scored high on emotional experiences were significantly related to good in-session events characterised

by reduced distress and making new meaning (Pascual-Leone & Greenberg, 2007). Another study revealed a reduction in depressive symptoms by incorporating clients' emotional involvement in cognitive therapy (Castonguay, Goldfried, Wiser, Raue & Hayes, 1996). Support for affect-based interventions has also been replicated in a group therapy format and generalised to eating disorders. Castonguay and colleagues (1996) explored the role of emotion in a 12-week group CBT for binge eating disorder and found that both positive (at the beginning and middle of treatment) and negative (middle of treatment) emotional client experiences were linked to therapeutic success. These findings suggest that information is more effectively processed in the presence of affect and emotional experiences (pleasant or unpleasant) and can be considered mechanisms of therapeutic change.

Additionally the overall utility of imagery rescripting and visualisation exercises was supported in ten Napel-Schutz et al.'s (2011) study, which explored patients' perspectives of imagery within ST. Comparing patients' experiences of imagery themes that emerged from ten Napel-Schutz et al.'s study indicated unpleasant feelings of uncertainty, anxiety, fear and annoyance associated with patients' experiences of imagery rescripting. In contrast, patients' responses in the present study regarding imagery rescripting were largely positive, of which some contained elements of surprise where the experience exceeded expectations. The disparity between current findings and that of ten Napel-Schutz et al.'s study could be due to the duration of time patients have underwent ST prior to the interviews: early phase or first three months of therapy (ten Napel-Schutz et al., 2011) and over 12 months of therapy in the present study. While imagery exercises were not explicitly



referred to as confronting and difficult, present findings suggested that patients do recognise the beneficial outcomes retrospectively and when they had some experience of these exercises.

Results from the current study found that learning schema concepts not only provided information on the origins of current behaviour patterns, but also clarified the mechanisms behind one's reactions in certain situations. In this sense, schema-related concepts afforded a language for patients especially when they have yet to develop words to describe their experiences and feelings. This generally occurred when distressing psychological material has been left under- or un-processed. The findings were consistent with the aims of promoting self-understanding and a sense of continuity from childhood in making sense of current difficulties, as outlined in the assessment and education phase of ST (Young et al., 2003). In contrast to psychoeducation that is commonly defined as the provision of information about the nature of symptoms and how to manage them (Wessely et al., 2008), the education phase of ST for BPD comprises the provision of information about one's self-defeating life patterns in response to maladaptive ways of construing the world (i.e. schemas). The distinction while subtle is more accepting and less stigmatising because it encompasses one's personality structure rather than limiting the focus on the disorder.

Patients' experiences with their group and/or individual schema therapists in the study involved a sense of support and safety to speak their minds without fear of being judged. Patients' perceptions of therapist qualities that enable a strong therapeutic relationship included attentiveness to their needs, non-judgmental attitudes and therapist self-disclosure. Without

specifying the type of therapist characteristics needed for ST, Young et al. (2003) recommended that the key therapist quality involved flexibility in adapting to meet each patient's emotional needs so that the patient can develop healthy behaviours modelled after the therapist. Current findings reflecting positive appraisals of therapists' attentiveness and attunement to their non-verbal behaviours during sessions were partially supported by Macaulay, Toukmanian and Gordon's (2007) study which examined the relationship between therapist-expressed empathy (i.e. attunement, tentativeness and meaning exploration) and client's level of in-session processing. Therapist attunement or "empathic responding" (Rogers, 1986) relates to the therapist's ability to observe aspects of the client's inner experiences in the moment and communicating these aspects back to the client (Bohart & Greenberg, 1997). Results from Macaulay et al. (2007) found therapist attunement as not only the central component of therapist-expressed empathy but also significantly related to enhancing client's depth and level of processing in therapy. Additionally, similar to current findings in favour of therapist self-disclosure in reducing the distance and unequalness between therapist and patient while increasing the sense of closeness to their therapists, a review of published quantitative literature exploring the role of therapist self-disclosure (TSD) in psychotherapy concluded that verbal TSD had positive effects on clients (Henretty & Levitt, 2010). For example, clients had a stronger liking for therapists who self-disclose and perceived them as warmer than therapists who did not (Henretty & Levitt, 2010). It is of benefit to examine patients' experiences of the therapy alliance as they help clarify what patients regarded as important in a schema therapist.

Even though patients in the Group ST condition did not have prescribed individual sessions, they were offered an optional bank of up to 12 individual sessions per year. Patient narratives representing both conditions revealed that some patients held a general preference for either group or individual ST, however there was an overall consensus that group and individual schema therapy is more effective when delivered together due to the different benefits offered in each therapy type. This finding is consistent with a pilot study that examined the efficacy of a two-year combined group and individual ST for BPD (Dickhaut & Arntz, 2013). Results from Dickhaut and Arntz not only replicated the significant improvements in BPD symptomatology and overall well-being reported in other studies (e.g. Giesen-Bloo et al., 2006), these gains were also higher than studies that looked at individual ST alone (e.g. Nordahl & Nysæter, 2005). While recovery from BPD is possible with solely the group component of ST (Farrell et al., 2009), present findings supporting the differential functions of group and individual therapy were consistent with results from de Zulueta and Mark (2000). The conjoint group and individual analytic therapy in the treatment of BPD were reported to serve a different function in each format; exploration of early injuries in individual and utilising the group as a “testing ground” to address any re-enactment of such traumas (de Zulueta & Mark). Taken together there appeared not only unique benefits of each group and individual therapy format that one would not be able to derive from the other, but also synergetic effects of a combined format in addressing concerns with the group/group members and further clarifying particular topics discussed during group.

#### **4.2 Group Factors that Contribute to Therapeutic Gains**

Patients' reported experiences in the group were consistent with some of the curative group factors described by Yalom and Leszcz (2005) including universality and instillation of hope. Patients' experiences of feeling connected in and belonging to the group were also described in Farrell and Shaw (2012) as a group therapeutic factor that amplifies ST interventions. Consistent with Farrell and Shaw's (2012) hypotheses, being in the presence of like-minded individuals had been helpful in enhancing feelings of acceptance and belonging at the same time reducing those of isolation. While patients in the current study did not explicitly refer to the instillation of hope as a therapeutic group factor, they indicated that ST had exceeded their expectations and any negative preconceived ideas about group based on previous therapy experiences were corrected.

In contrast to Yalom and Leszcz (2005)'s expectation that witnessing group members who improved as a result of therapy could instil hope in others, present findings revealed patients' annoyance toward themselves for not progressing as quickly yet feeling better about themselves when comparing to those who disclosed their difficulties and struggles. This belief clearly captures the Failure schema where one feels inadequate relative to their peers (Young et al., 2003). Compared to Yalom and Leszcz (2005), the discrepancy in group members' experiences when others improved could be due to the nature of the <sup>17</sup>population type within the group and type of improvements made. BPD patients tended to be punitive towards themselves (Whewell, Lingam & Chilton, 2004; Young et al., 2003) and would possibly find it difficult to accept

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<sup>17</sup> Cancer patients in Yalom and Leszcz (2005); BPD patients in this study

that they could make those improvements therefore instead engage more easily in self-blame.

Consistent with Farrell and Shaw's (2012) speculation, another change catalysing factor attributed to the group included verbal contributions (e.g. words of encouragement, validation) from peers within the group as opposed to group facilitators. While patients in the current study generally described a positive therapeutic alliance with their group therapists, providing feedback was perceived as part of their job and in that sense some patients found it less "powerful" than hearing it from group members. Farrell and Shaw recognised the difference in impact between empathic confrontations that came from group members and therapists. It was hypothesised that group members felt less threatened and their defensive coping modes did not get triggered.

As predicted by Farrell and Shaw (2012), socialisation that occurred outside therapy group was a positive experience for patients. Friendships formed and regular contact outside group had provided support for patients in the Group ST condition. Farrell and Shaw supported this phenomenon as a learning experience indicating successful transition from therapeutic group relationships to a healthy adult peer group. Even though problems that occur during interactions outside of group can be difficult to resolve in the absence of group therapists, Roth (2007) addressed the issue of boundaries and counter-argued that outside contact can bring to attention any discrepancy between one's behaviour within and outside of the group. In contrast, patients in the Combination ST condition did not succeed in establishing contact with each other outside of therapy. The stronger relationship bonds among patients in Group ST condition as compared to the Combination ST condition could be

explained by a range of factors. These included different frequencies of group therapy sessions, varying number of group members between each condition, group composition and possible therapist factors/characteristics.

While the utility of experiential techniques was reflected in patients' narratives, most of them were discussed within the group as opposed to the individual context. It appeared that these exercises "stand out" to patients due to the enhanced affect change that accompanied. Yalom and Leszcz (2005) believed that irrespective of therapy approach, group setting provides more opportunities for corrective emotional experiences. This is because even in the absence of additional stimulation, the group already contains tensions attributed to members' interpersonal styles and personalities (Yalom & Leszcz, 2005). Farrell and Shaw (2012) added that the group offers extra resources (e.g. numerous characters for role plays) in enhancing the experiential experience for patients.

### **4.3 Factors that Disrupt Group Climate**

Interpersonal conflicts are commonly present in all human relations and unavoidable in group psychotherapy. In fact it is generally accepted that conflict is essential to group development because ability to effectively deal with conflict contributes to individual maturation (Ormont, 2002; Yalom, 1985). However it becomes a problem when the conflict was not adequately managed to the extent that it compromises group members' sense of safety in freely expressing themselves (Unger, 1990). This phenomenon was reflected in the current findings where a particular incident/conflict involving a few patients had left them feeling unsafe to speak their minds and subsequently not daring to

contribute as much as before. The findings suggested the presence of an impasse that can stifle personal growth and implied that tension could linger even if a conflict appeared to be resolved at that point in time.

Consistent with sources of hostility outlined in Yalom and Leszcz (2005), patient narratives also suggested the experience of rivalry and the perception of needing to compete for attention within the group. It is of interest to note these patients were the same group members who reported feeling excluded from the group and unsafe to express themselves following a rupture during group therapy. Even though it was impossible to tease out which event occurred first (i.e. whether the perception of not being sufficiently attended to precedes feeling excluded or the incident/rupture led to feelings of exclusion and isolation), it is suffice to say these three themes existed in a relational sense involving a relationship that could reinforce one another in an unhealthy way. Yalom and Leszcz argued that while permanent removal of conflict is not the goal, group therapists needed to harness the conflict by facilitating the group to reflect on their experience of the conflict. Effective conflict management within group is achievable upon the condition that group cohesiveness is first established (Yalom & Leszcz). Specifically for group ST when the group is threatened by disruptive behaviours, Farrell and Shaw (2012) recommended reinforcing ground rule reminders, empathic confrontations, limit setting, and physical removal of a member if necessary.

#### **4.4 Termination of Schema Therapy**

Unsurprisingly as the ST program approached its end, some patients in the study found the tapering of group and individual sessions disruptive and

had difficulties with each <sup>18</sup>transition. Similarly feelings of fear and disappointment arose when patients felt they had not made enough progress. Regardless of the therapy approach, termination can be a challenging process filled with loss and pain particularly for the BPD patient who may experience a greater sensitivity to such issues (Winograd, Cohen, & Chen, 2008). For these reasons Arntz and Van Genderen (2009) suggested negotiating with BPD patients an end date, addressing concerns with termination during treatment well before its end, building up their resources/skills and ensuring therapists become available in times of crisis and important events in patients' lives. It was observed in the study that patients who raised their dissatisfaction regarding the duration and decrease in frequency of therapy were interviewed at least 18 months after therapy had commenced (six months remaining). While the appropriate time to bring up termination of a two-year-long ST program for BPD has yet to be established/determined, present findings implied the need to address patients' concerns regarding termination.

#### **4.5 Study Strengths**

Several strengths are related to the methodology and data analysis of the study. First, themes in the coding frame were formulated based on 28 interviews: 10 German, 10 Australian and 8 Dutch interviews. This sample size ensures that data saturation has been achieved and results were not restricted to idiosyncrasies of patients at the Perth sites. Second, the research team was involved in various stages of the data analysis process. In particular multiple coding was carried out with the help of two other researchers where all 26

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<sup>18</sup> Weekly during the first 12 months to fortnightly in the next 6 months to monthly in the last 6 months



interviews were double coded and crosschecked. Additionally an average Cohen's kappa of .74 was achieved for each theme to ensure the quality of analyses. Third, an informant feedback was sent to all patients so that any misinterpretation of the interview data can be corrected. In this way interviewer subjectivity would be minimised which enabled more objective interpretation of the interview data. Finally, two patients participated in the interview even though they have discontinued the schema therapy program and they shared reasons for their departure. It is therefore likely patients were honest in their interviews as both positive and negative experiences were captured.

#### **4.6 Limitations**

Some limitations of the study have been identified. The length of time patients had underwent ST by the time of interview was not controlled for and it differed from patient to patient ranging from 12 to 22 months. Similarly patients were in either of two therapy conditions: Combination ST or Group ST condition. These may indicate differential experiences consistent with the respective time points in ST and type of therapy condition they were allocated to. Other limitations involved the challenges of translation. Although all the German and Dutch interviews were translated to English, it was inevitable a certain degree of meaning became lost in translation. While the third researcher who assisted in double coding is a Dutch and not a native English speaker, she had personally conducted the Dutch interviews and was able to explain sentences that were incorrectly phrased in the English language. However during the process of deriving the inter-coder agreement most disagreements arose from the German interview transcripts. This in turn impacted on the

understanding of the German interpreted experiences, reducing the inter-coder agreement.

#### **4.7 Clinical Implications and Conclusion**

Several areas of significance have emerged from current findings that are relevant to patients with similar conditions, mental health professionals, and existing and planned mental health policies. These included but are not limited to:

1. Reported gains (e.g. increased confidence levels) made by patients as a result of ST implied and reiterated its utility with the BPD population.
2. While aforementioned gains may signify the recovery process, recovery from BPD is an individualised process and can be represented in more ways than one. Various conceptualisations of what recovery from BPD means could be further explored, perhaps at some point in therapy to ensure patients' personal goals of recovery are addressed.
3. The necessity of undergoing challenges and difficulties faced in ST (e.g. revisiting one's traumatic past) indicated the potential for things to get worse before they can get better. That is to say it may be worthwhile completing the entire course of ST to reap therapeutic gains.
4. Regardless of therapy condition (i.e. Group ST or Combination condition), study patients supported the option of prescribed individual ST sessions in addition to group ST because of the unique contributions of both components. It appeared that ST in a combined group and individual format would be most beneficial for BPD patients; individual ST alone is limited in providing a realistic environment to apply and

experiment with techniques/skills learnt in interaction with others while group ST alone does not afford sufficient space to explore one's issues at a deeper, more personal level.

5. The utility of experiential learning (i.e. practising learnt coping skills during group crises) reinforces the value of capitalising on conflicts and feelings of distress that occur in the moment during group therapy.
6. Similarly helping patients understand mechanisms behind the use of suggested coping strategies could increase the likelihood of implementing the learnt strategies when needed.
7. The immediate/instantaneous impact that experiential techniques have on patients encourages its continued use within the schema model. However they should be delivered in a timely manner with careful assessment of the patient's mental state, knowledge of and accessibility to adaptive ways of coping.
8. The extent to which negative impact of conflict during group ST was lingering/lasting and the ability of group members to mask/hide their dissatisfaction even after resolution of conflict suggested the value of paying close attention to group processes, particularly silent factors (e.g. a sense of disengagement) as they can impinge on treatment efficacy. There were also a few patients who felt unsafe expressing how they feel for fear of upsetting others or being at the receiving end of intense emotional responses. This indicated the need to strengthen the sense of safety within group and for more effective management of group conflict: not to the extent that conflict is eliminated but sufficiently resolved such that it creates space for open, honest discussions.

9. Negative group experiences described by patients reflected the activation of several schemas and indicated the potential for managing schema groups differently to create more positive experiences and these include:
- Even though there exists a sense of connection among most group members, a few patients described feeling isolated and different from others. This suggests refining the selection process, perhaps allocating patients to groups based on similar problem profiles.
  - More work in the group could focus on dealing directly with the schemas in operation (e.g. Failure, Social Isolation/Alienation, Emotional Deprivation) that could sabotage the therapeutic processes during group ST.
10. Patients' experienced anxiety and frustration over their perception of not recovering fast enough suggest the need to directly explore their expectations and beliefs early in the group. In particular assisting patients to identify realistic, achievable goals can increase their awareness that maladaptive patterns of behaviour take time to change, thereby reducing the risk of setting themselves up for failure. Group therapists should also perhaps pre-emptively target this process as it relates to schemas such as defectiveness and failure.
11. Based on a two-year-long schema program and considering the uniqueness of individual needs, it is important to note an appropriate time to begin the discourse regarding termination so that patients can have an open discussion of their concerns.

The study has attempted to capture patients' experiences of ST. Therapeutic gains identified by patients (e.g. changes in confidence levels, connection with one's emotions) were beneficial to the extent they promote flexibility in one's cognitions and make behavioural changes accordingly. For example, reduced fear/increased confidence was shown to enhance patients' ability to experiment and reality-test without subscribing to previously held beliefs that things would go wrong. Distinctive components of the schema model in facilitating such benefits included the use of experiential techniques, schema-related concepts, therapeutic alliance, flexibility within the schema model, and the complementary nature of group and individual ST. Patients' broad perceptions also indicated the necessity of acknowledging and dealing with one's past/history where relevant, considering the uniqueness of individual needs and permitting flexibility in adapting aspects of the schema model to the group context.

Change catalysing factors do occur naturally within group irrespective of treatment approach such as the sense of connection/universality, interpersonal learning and contribution/input from like-minded group members. Nevertheless the utility and impact of particular aspects of ST (e.g. experiential techniques) becomes amplified in a group setting. The course of receiving ST has evidently contributed to meaningful progress in patients' lives. Identified specific mechanisms of the schema model and non-specific therapy ingredients responsible for these gains will not only create opportunities for improving the schema protocol but also enhance current understandings of their interactions that help shape recovery from borderline personality disorder.

## Chapter Five: Method – Therapist Participants

### 5.1 Schema Therapist Profiles

Participants in the therapist group consisted of eight Schema therapists, one male and seven females as seen in Table 6 below. One of them was a mental health nurse, three were social workers and four were clinical psychologists working at an outpatient psychiatric facility. They all received the seven-day training program certified by International Society of Schema Therapy (ISST). Two of them were trained as group schema therapists, four as individual schema therapists and the remaining two played the dual role of group and individual schema therapists. All but two therapists had also completed postgraduate clinical training. Schema therapists ( $n = 8$ ) provided their informed consent and accepted to participate after the aims and procedures had been described (See Appendices H and G respectively). Therapist interviews were conducted at the therapists' private office spaces or interview rooms at Murdoch University.

Table 6

*Schema Therapist Profiles*

Therapist Codes	Therapy Type	Education Type	Therapy Experience (years)
#1	Individual	Clinical Psychologist	15
#2	Individual	Clinical Psychologist	10
#3	Individual	Other Allied Health	17
#4	Group	Clinical Psychologist	16
#5	Group	Other Allied Health	21
#6	Individual	Other Allied Health	11
#7	Group and Individual	Other Allied Health	10
#8	Group and Individual	Clinical Psychologist	10

**5.2 Schema Therapy Supervision**

Supervision was provided via video-conferencing within a group setting of one hour duration weekly for all therapists in each site by two advanced level schema therapists Joan Farrell and Ida Shaw. Therapists at the Rockingham site also received individual supervision when needed.

**5.3 Procedure**

Similar to the Topic List developed for BPD patients, the Topic List for schema therapists (See Appendix I) developed after various discussions with the research team, was to guide the in depth semi-structured interviews. A flexible interview style was adopted and therapist interviews lasted between 55 and 90 minutes. All interviews were audio-recorded with a digital recorder and

transcribed verbatim. An informant feedback was then sent via email to each therapist to comment and correct if necessary. To ensure adherence to the Schema therapy model, video and audio recordings of group and individual schema therapists conducting schema sessions respectively were observed and rated by independent researchers.

#### **5.4 Data Analysis**

Therapist interview data were analysed following the process of qualitative content analysis. Emergent coding frame for therapist interviews was developed and once the core themes were generated, the research team collaboratively discussed and provided feedback to further refine the coding frame and interpretation of data. This process was achieved through monthly meetings over Skype.



## **Chapter Six: Results – Therapist Participants**

All eight schema therapists were interviewed after conducting schema therapy between 18 to 24 months. Two overarching themes emerged and are classified accordingly in this chapter. Part one explored group and individual therapists' broad experiences of working with BPD patients while adhering to the schema therapy protocol, together with therapists' impressions of ST training and supervision. Part two focused specifically on group therapists' experiences within the group and factors therapists perceived as necessary for the schema group to be productive.

### **6.1 Part One: Group and individual therapists' broad experiences in providing schema therapy**

Four topic areas relating to all eight therapists' broad experiences of providing ST were identified, as presented in Table 7 below. Themes included A) Overall experiences of delivering ST, B) General aspects and specific elements of the schema model perceived as therapeutic for patients, C) Perceptions of ST as compared to previous therapy experiences, and D) Impressions of ST training and supervision.

Table 7

*Therapists' Broad Experiences in providing Schema Therapy*

Topic/Category	Themes/Subcategories	n
A. Overall experiences of delivering ST	Extent to which experience was rewarding	6
	Self-understanding and awareness of others' modes	6
	The use of the schema framework in one's profession	4
	Novel experiences of behaviours that are difficult to manage	4
	Extent to which experience is anxiety-provoking	3
	Strong transference reactions to patients' experiences	3
B. General aspects and specific elements of the schema model perceived as therapeutic for patients	Extent to which ST provides insight	4
	Utility of imagery and role-play exercises	4
	Schema concepts provides a new language	4
	Therapeutic relationship	3
	Balance of patient's and therapist's agenda	3
	Humour and playfulness in therapy	3
	Extent to which group and individual ST complemented each other	3
C. Perceptions of ST as compared to previous therapy experiences	Extent to which ST is prescriptive and focused on affect	5
	Process work involved	3
	Depth with which ST works	3
	Flexibility with one's boundaries	3
D. Impressions of ST training and supervision	Use of experiential techniques/learning during training	8
	Feelings of enthusiasm and inspiration by the training	4
	Space for discussion in supervision	2

### 6.1.1 A. Overall experiences of delivering ST

Therapists' responses of their overall experiences of ST were varied, ranging from rewarding experiences and developing a strong sense of connection with patients to feelings of frustration and anxiety. Slightly over half of the therapists discussed changes made in their personal (e.g. increased understanding of themselves) and professional lives (e.g. incorporating elements of schema therapy in their professional career). Some therapists also described being placed in situations they had never experienced before while working with BPD patients in this schema study.

#### A1. Extent to which experience was rewarding

The majority of therapists ( $n = 6$ ) enjoyed and spoke positively about their overall experience using a variety of descriptors including “awesome”, “worthwhile”, “great”, “rewarding”, “remarkable” and “good”. Therapists generally endorsed this item as a reflection of the shifts and benefits made by patients (e.g. when patients gained insight of the difficulties in their life and made appropriate, observable changes). *“When they have an epiphany and then things change for them. That in itself is just perfect it’s just great, a move you can actually see that person quiver a notch... when you see the change taken place in that person their behaviours or their thoughts have modified in some way shape or form that’s great I just feel so good about them, feel so good about myself being able to help them feel that”* (therapist #6). Three therapists expressed that this strengthens their belief in the effectiveness of the schema model. *“Worthwhile to the therapists cause’... if it’s a positive experience for them then yeah that’s my proof that something’s working cause’ they’re feeding*

*back, they're applying it, they're telling me that so I see them do so that's great" (therapist #1). Another therapist found the experience rewarding not only professionally but also contributing to personal growth/understanding. "It has been very rewarding with the schema therapy, I think both professionally and personally it has been very rewarding. Professionally have noticed quite a lot of movements with each of the participants... the changes that we have seen with them in the schema has been remarkable. Also with that is that sense of empowerment that I have noticed with the group participants... they have a framework of understanding around their modes... I find that as a therapist you really need to be true as to where you are at because you need to be so open and transparent both in the group and individual settings more so I think compared to other therapies used... So I think for me... you've got all of that is going on in our personal life, I need to revisit that a little bit to make sure that I was in a good space especially during group share, whereas with other groups I have not had to be as disciplined" (therapist #7).*

## A2. Self-understanding and awareness of others' modes

More than half of the therapists ( $n = 6$ ) noticed that they are more aware of their own modes and other people around them in their personal and professional work. Therapists described paying more attention to their triggers and how these can interact with patients or people in their personal life. *"I'm more aware of my own modes, I've become more aware of my own modes and observing my modes in therapy, what's getting triggered for me and so I've become more aware of the transference counter-transference... And it's helpful if you know what buttons are getting pushed and what ones you're pushing"*

(therapist #1). One therapist also described learning to step back rather than immediately responding to certain situations. *“You learn stuff about yourself don’t ya? You look at modes you oh I’m a healthy adult I’m a happy child or whatever. If something happens in my life, and my reaction I’ve learnt to stop and stand back and look... I find that I can apply to my own life but I also find I can I can look at the theory in terms of other people too”* (therapist #6). Two therapists rated this self-awareness as important in ensuring personal issues do not interfere with therapy. *“Things will get activated in you in relation to the person that is in front of you and as best as you can as a therapist to be aware of that and be watchful of yourself and the way you can be destructive have a negative influence on the process and it be largely outside of your awareness”* (therapist #2).

### A3. The use of the schema framework in one’s profession

Four therapists found themselves using elements of the schema framework increasingly with other patients in their external therapeutic work. Therapists generally described how conducting schema therapy in the study has impacted on their line of work with patients and altered the style with which they interact with them. *“A life-changing experience for me over and above the study itself... you see I use certain aspects of CBT in nursing I use certain aspects of DBT but now I also use schema focused therapy and I found that I’m less- I still have the interest but I don’t incorporate that into my care now. I now use parts of schema... there’re parts of schema therapy that you actually can use and that I do use and that’s changed my life my certainly my working life in the way I present myself in the way I question the people in mental health*

*assessments” (therapist #6). One therapist who predominantly used an “eclectic” approach now identified as a schema therapist. “I almost describe myself as a schema therapist as opposed to any other form of therapy. And again I know the CBT sits behind it, but you’ll get therapists that will say that behaviourists or cognitive and that’s where their emphasis is and I never say that, I saw myself as quite eclectic, that I draw from whatever seems to fit the client. So, schema fits the client... Only with my words of- like identify myself or like to identify myself... I identify myself as a schema therapist... I sort of do. Yeah, that’s where I tend to go, and that has been more so since the group started” (therapist #8).*

#### A4. Novel experiences of behaviours that are difficult to manage

This theme was salient for four experienced therapists where they described never having such challenging behaviours in their therapeutic careers. Two therapists observed that anger is a common emotion expressed by patients in ST, particularly during the initial stages of therapy and this can stir up one’s own feelings. *“There’ve been times that the girls have gone into the more angry space and it hasn’t been angry child or teenager to deal with, it’s been more bully-attack or angry protector and having to deal with that can be ‘Holy Cow’... Because it triggers your own modes and you need to be managing those” (therapist #8).* The impact of being at the receiving end of patients’ intense anger and subsequent expression of anger in response to the patient’s behaviours was also discussed. *“I have never in all my therapy experience got so angry and I just I let her have it back you know which I apologised for and repaired it in the next session but she got it and appreciated*

*me being – she was like “wow wow” you know that really had a profound impact on her and it had a profound impact on me cause’ I have never done that in my therapeutic career before. I was really angry with her I was really angry”* (therapist #1). An experienced group therapist described the group as one of the most difficult with therapy-interfering behaviours exceeding those in her experiences with previous groups. *“We’ve had a lot of people up and leaving group, people not turning up a lot of therapy-interfering behaviour which I mean you do get with borderline clients. I work with borderline clients with DBT and I don’t get nearly as much therapy-interfering behaviour”* (therapist #4).

#### A5. Extent to which experience is anxiety-provoking

Therapists ( $n = 3$ ) generally described feeling anxious and at times unsure of the best direction to take with the patient. They tended to question their abilities as a therapist and felt less confident at different points in therapy. Two of them recognised that they were very hard on themselves and this anxiety was part of their personality structure of wanting to be the best they can for the patients. *“I think anxiety for me was more, which was my own stuff. Was more around my interpreting and wanting to do the best for the group member and I think that’s part of my personality is structured that if I feel that I haven’t got full concept of the theory or haven’t read it to death, because that manages my anxiety- If I have not gotten the full bottle on it, then I feel like I’m not going to be the best for this group. If I look at the modes to explain myself, I think I have a very strong demanding voice and as a result have very strong anxiety attached to that”* (therapist #7).

## A6. Strong transference reactions to patients' experiences

Three therapists experienced and recognised strong transference feelings in response to what was shared in sessions. They described intense emotions that arise within themselves and then making room for these emotions while bringing the focus back to the patient. *“Then some of them can be very silent. You know when vulnerable child abandoned and crying and distressed and it can be very very sad to deal with – to hear those experience that have never been validated and it’s almost as if you’ve got an 8-year-old who’s very distressed who’s right in front of you ... the transference you would feel for that that vulnerable child their experience you feel that”* (therapist #1). One therapist also described such moments positively due to connection shared with the patient. *“It makes me feel tearful and really feel for the person but even though that’s a sad moment it’s also a happy moment for me too because I’m feeling what they’re feeling”* (therapist #6).

### **6.1.2 B. General aspects and specific elements of the Schema model perceived as therapeutic for patients**

While some therapists described the general therapeutic aspects (e.g. therapeutic relationship, ST provides insight) of ST, some therapists also made specific references to elements of the schema model (e.g. imagery, role-play exercises) that lead to beneficial outcomes for patients.

## B1. Extent to which ST provides insight

Half of the therapists found ST helpful in providing patients an understanding of themselves. This insight as reflected in therapists' narratives,



allowed patients to recognise the origins of their difficulties while reducing self-blame which subsequently created a change in their behaviours. *“I think probably just through their growing awareness of themselves and the origins of their difficulties it makes it makes a difference for them I hope it helps them to change their behaviour and how they view themselves and what causes them the difficulties that they have... why they react as they do, why their emotions are evoked as they are in different situations and following that their behaviour”* (therapist #2). Other therapists attributed patients’ improved insight to the use of techniques outlined in the schema mode model (e.g. reparenting, imagery rescripting) to increase self-understanding. *“The first time after so long she had some insight and empathy towards the vulnerable child she saw an imagery of that child and she was very emotional and that was a good change for me to see her recognise and accept and acknowledging that “I was only a vulnerable child, it was not my fault” and then deal with some interpersonal dynamics in a healthier way”* (therapist #1).

## B2. Utility of imagery and role-play exercises

Four therapists commented on the usefulness of imagery and role-play exercises in facilitating self-understanding through affective experiences. Therapists found imagery helpful in speaking up for, delivering messages to and providing validation to the patient when appropriate. *“We could do the re-imagining which is one of the techniques. And we could articulate the outrage to the parent that wasn't protective... that actually denied her version of events and did not then give her a message about how outrageous it was”* (therapist #3). Additionally, two therapists acknowledged that imagery is powerful

enough to create a positive shift within the person almost immediately.

*“Rescripting is- it’s really really good, very very effective and you see that effect you see that when a person’s finished a session it’s almost like you’ve just lifted a whole weight off their shoulders their whole persona seems to change”* (therapist #6).

### B3. Schema concepts provides a new language

Four therapists described the schema terminology as “a language” that is easy for patients to understand and allows patients to “name” their needs. Therapists observed that patients learnt the “language” quickly and were able to apply the schema concepts in their daily life. *“They appear to take on board the therapy and actually own it... They tend to talk more in terms of, using language around the therapy. And I’ll actually run with it. They tend to be a little more a little more ahead of you, they will research it, some of them will research it, and this is outside of group. And they pick up the language really quickly and it becomes everyday for them”* (therapist #8).

### B4. Therapeutic relationship

Consistency of the therapeutic relationship was another aspect therapists perceived as beneficial for patients in ST. Among the three therapists who endorsed this item, there was a general consensus regarding the value of consistently creating a holding environment for patients regardless of patients’ emotional states. One therapist described the therapist roles as “therapeutic containers” and this provides patients the space to express themselves without fear of damaging the relationship. The process of being role models and validating patients’ experiences (i.e. reparenting) was also emphasised by two

therapists in facilitating positive outcomes for patients. *“Consistency in the modeling they get from the facilitators... I guess that’s the whole part of schema therapy is, you know we’ll look after the vulnerable child, and have them learn, hear those good messages that they possibly never had as a child or were unable to hear. So there is a degree of modeling for them to then use, those skills... It is the consistent messages that they are receiving that are appropriate. And again, the consistency in the therapist, whether it’s in individual or a group setting and I guess it’s any therapy in particular, with that client group, they need the therapist to be the same basically each time they see them. And they know they can come in and have a wince at them and it’s not going to have an impact on the relationship”* (therapist #8).

#### B5. Balance of patient’s and therapist’s agenda

Three therapists (i.e. two group therapists and one individual therapist) described the importance of providing space for and paying attention to what the patients bring in to the sessions. Regardless of group or individual ST, it is necessary to strike a balance between validating patients’ needs and adhering to the schema model. In this way, patients’ needs are attended to and this sends the message that what they have to say is important. *“If your agenda is more important than the clients’ then that’s not therapy. The client has to set the agenda and you can have input into their agenda... you have to work with what they bring... So you have to be very prescriptive you have to make sure you’re adhering to schema and the schema modes but not invalidating all the other stuff”* (therapist #1).

#### B6. Humour and playfulness in therapy

The use of humour in therapy was regarded as helpful to patients ( $n = 3$ ) in creating a less serious and more relaxed therapeutic climate. One therapist commented that this allows patients to have a potentially different and enjoyable experience as compared to the past. *“There's some humour and playfulness I think that's incredibly helpful, and almost giving them permission to do that because it's all sort of, possibly they just didn't have a childhood because it was serious at home or they're defending themselves or their just shut down in order to survive their childhood”* (therapist #3).

#### B7. Extent to which group and individual ST complemented each other

The complementary nature of group and individual ST was discussed by three therapists. Therapists found the group component helpful for patients to foster connections with other individuals and allow them to learn they are not alone in their problems. In addition therapists also discussed the individual component as a good adjunct to group ST by affording each patient more tailored focus and attention to work through difficult times in their lives. *“I think group's helpful for borderline clients but they definitely need the individual to work the traumas, because the people that we had were very traumatised- difficult childhoods difficult adult lives and- we can't even scratch the surface in group...I think it's a good match, one group one individual I think 2 sessions a week is good but one where the focus is very much on them and one where there's not such a focus and they can look more at how they respond and react to people around them”* (therapist #4).

### **6.1.3 C. Therapists' perceptions of ST as compared to previous therapy experiences**

All therapists made comparisons of the schema model to therapies they have previously conducted; differences were categorised across five themes, as summarised below. The majority of therapists have been well trained and experienced in using cognitive behavioural therapy (CBT) and dialectical behavioural therapy (DBT). Despite some discomfort regarding the intensity and need to think on one's feet when conducting ST, therapists generally found ST to be effective in going beyond the surface and addressing the heart of the problem.

#### C1. Extent to which ST is prescriptive and focused on affect

Five therapists considered ST as having a stronger focus on affect and emotions, at the same time being less “prescriptive” in terms of following a fixed structure. *“DBT is more behavioural and more prescriptive you have to stick to the script, 3 strikes you're out you know schema... it focuses on the affect and that's what I like it's the emotional component you're focusing on the emotive changing the affective component and that's what I like get to the feelings”* (therapist #1). One therapist stated “schema considers the person” whereas “DBT focuses on the skills, and misses the person”. Therefore in this regard, ST is considered more validating. *“That frame work with DBT was not validating as what schema could be. So for instance if she was struggling and DBT is very skill based of a group as well, if someone was struggling within the group it would be very much validating, acknowledge and I care what strategies could you use to manage the distress you are in. How to use your distress tolerance, how to use self-soothing, whereas I think schema the tack would be is very different to that... I find there is a risk with some clients, it can be quite a little bit dismissive or invalidating. So it is around “okay I see you*

*are sad, I acknowledge that, what strategies could you use to manage your sadness?” as opposed with the schema it is around “I consider that a level of sadness you know what mode could that be of vulnerability? When was the last time you felt this vulnerable, when was the last time you felt like this can you bring that image forward?” It is a whole different way” (therapist #7).*

Therapists also stated that there are differences between a discussion at an intellectual and emotional level and the experiential techniques in ST facilitate the expression of such feelings. *“When you do the experiential techniques with the client that’s very different to talking about just talking about it on an intellectual level because the feelings get evoked in session. The different exercises you might do with the chairs you know the mode work” (therapist #2).*

## C2. Process work involved

Three group therapists felt the need to constantly pay attention to patients’ behaviours and where they were at in the moment. In this sense, therapists perceived each session as “unpredictable” and not being able to fully prepare for it. Instead, they described needing to “think on their feet” and be quick in responding to whatever is happening for each patient. One group therapist added that it is therefore necessary not only to be alert and mindful of one’s own headspace, but it is also important to be in sync with one’s co-facilitator within a group setting. *“I think with schema I just feel that you have to be more on your toes... I think is every group is doing that, thinking on your feet and you have to be really in touch with where you are at to be able to do that” (therapist #7).*

## C3. Depth with which ST works

As compared to other therapy approaches, therapists ( $n = 3$ ) found ST to operate at a deeper level, which “gets more to the heart and meaning of things”. One therapist experienced ST to directly address the core underlying issue rather than provide solutions to the presenting problems. *“In the present, I am influenced by DBT, you go into that little core analysis and try to look at where they made a crossroad where they could have went different behavior and you're not getting to the root of the problem where they gone back... It's like my problem solving... I go like this to look at how else she might have handled the situation and you do the CBT interventions... It doesn't help with the wound. The wound is what's driving this behavior, of being ignored... I think that's how Schema is helpful because it keeps you on track to the emotional distress rather than- which would have been my normal mode of operation, to be constructive about it”* (therapist #3). Similarly there is a deeper connection with the patients and while it can be more difficult to establish that relationship, it can be rewarding. *“You can be a little more human in it compared to other therapies, the limited reparenting stuff you know you can be a bit more accessible... some of the work we do here is very psychoeducational, so you might not necessarily share an experience or discuss some of the aspects that you might do in schema therapy when you try to illustrate a point... I guess you know you're working at a deeper level with people so it requires more trust and you know you have to work a bit harder to get that connection that can be very rewarding that's quite enjoyable”* (therapist #4).

#### C4. Flexibility with one's boundaries

Three therapists described ST as involving more flexibility in terms of boundaries such as being more themselves or “real” during the sessions and providing out of hours contact. *“I think with schema you would use self-disclosure etcetera I would not normally be open to using it myself... if it’s relevant to the client I will but it’s uncomfortable for me to do it... your boundaries have to be different you have to be more fluid with your boundaries that you would normally be. You have to follow them up you know you have to be more proactive you have to be on the receiving end of some very angry children”* (therapist #1). Therapists also experienced that the delivery of ST can at times be “confronting”. They described the nature of ST as “fluid” and that there is no “full structure to hold on to”. In this sense, therapists’ comments reflected the challenge of having to respond in that moment while sitting with whatever is presented by the patients rather than “hide behind” one’s knowledge of a particular set of skills. *“Personally doing schema is quite confronting, because...when I’m not really certain as to what I am doing it’s good to be able to hide behind your knowledge or your skills or like DBT for instance. With the schema mode therapy it is hard to hide behind that, like you cannot because it is such a fluid nature of therapy. I find you cannot hide behind a module so to speak. So... if someone was angry for instance I could go and use the skills of DBT and say... “let us go through the distress tolerance strategies, okay what strategies can you use here to manage your anger at the moment?” So identify, validate, acknowledge and choose the skills, so I can hide behind that. So if someone is angry in the schema mode it is very much sitting with that emotion of anger. “You seem angry what mode of anger do you think that could be?” Part of you is not wanting to dampen that emotion,*



*especially if you have someone that has not had the opportunity or possibility to be angry. So you want this safety that the group can provide and the facilitators can provide for them to be able to experience that anger, not dampen it down by using strategies” (therapist #7).*

#### **6.1.4 D. Impressions of ST Training and Supervision**

Therapists’ evaluations of ST training in retrospect revealed the utility of learning through practical experiences. While therapists complimented on the trainers and the delivery of schema knowledge through ST training, due to the dynamic nature of ST, two therapists also found the training limiting in providing full confidence when dealing with patients within a schema framework.

##### **D1. Use of experiential techniques/learning during training**

All eight therapists found the experiential work and observations during training helpful, using descriptors such as “powerful”, “valuable” and “beneficial”. Therapists recognised the differences between learning through theory and through practical situations. They described that the large focus placed on the experiential work was “well placed” and this “consolidates the theory”. They described that role-plays allowed therapists to get a sense of what it is like being in the patients’ shoes. *“I love the roleplay, without a doubt definitely because it actually puts you- it gives you an idea of how another person’s gonna react by our own reaction”* (therapist #6). While one therapist described the training as “intimidating”, it was also described as “valuable” and provided many opportunities for observing and learning from not only the facilitators but also other clinicians. *“I thoroughly enjoyed the training. I think*

*with the group facilitating with Joan and Ida I have found that extremely valuable because the way I learn is very much as a observer and then do role plays that is how I learn, even though I hate the role plays... As intimidating as that is, looking at how they work it was good in that it gave myself numerous opportunities to observe Joan and Ida work but also for other staff members to be facilitators in the role play frame work and kind of really grasping their techniques that I would not been exposed to otherwise” (therapist #7).*

#### D2. Feelings of enthusiasm and inspiration by the training

Four therapists recalled feeling inspired after the schema training. They described that while the workshop only lasted a few days, it left them with the motivation and desire to learn more about schema. One therapist stated being “enthused” and described being ready and prepared to start. *“I was very enthused and I couldn’t wait to get started”* (therapist #6). Another therapist regarded the facilitators highly and specifically complimented on their energy levels having an “incredible” impact on the training workshop. *“That was hugely beneficial. The energy that Ida and Joan brought to the training was incredible. Really just wanting to channel both of them and knowing that it would take forever to get to where they are”* (therapist #8).

#### D3. Space for discussion in supervision

Two individual therapists commented that the supervision placed too much focus on group processes, leaving little room for individual supervision. For both therapists, this was their first time conducting schema therapy and while group supervision was “helpful” in terms of discussing each patient within the group, supervision did not sufficiently address and provide feedback

needed for the specific issues they had with each of their individual patients. *“I would have preferred much- much more closer individual supervision to guide me that that’s a difficulty I’ve had, we had some here and there but we have had much more regular group supervision that’s been set out from the beginning and that’s been largely very regular and it’s helpful but it’s not sufficient for individual”* (therapist #2).

## 6.2 Part Two: Group therapists' experiences within the group

Therapists' narratives reflect emergent themes relating to significant experiences as a group schema therapist. Two topic areas were identified as reflected in Table 8, including A) Experiences as a group schema therapist/being part of the group, and B) Factors necessary for schema group to be productive.

Table 8

### *Experiences as a Group Schema Therapist*

Topic	Themes	n
A. Experiences as a group schema therapist/being part of the group	Extent to which therapists feel rejected and dismissed	3
	Levels of confidence in managing the group change with time	3
B. Factors to consider for productive schema group	Relationship and dynamics between co-facilitators	4
	Risk of deterioration as a result of group participation	3
	Sense of group-mindedness among others with similar experiences	3
	Debrief after each group therapy session	2

### 6.2.1 A. Experiences as a group schema therapist/being part of the group

All four group therapists had both pleasant and unpleasant experiences as a group schema facilitator. They described feelings of frustration and

rejection from patients, primarily due to therapists' perceptions of patients' inadequate commitment when they fail to turn up for group sessions. However three of four group therapists also noted the rise in confidence levels as group therapy progresses.

#### A1. Extent to which therapists feel rejected and dismissed

All but one group therapist ( $n = 3$ ) expressed feelings of frustration, rejection and dismissal when patients do not turn up for group therapy. This not only creates difficulties for group therapists due to the need to constantly recap certain topics that have been previously discussed, slowing down the therapy process and disrupting the group connection, it can also overtime lead to emotional fatigue. *"You're working at a deeper level with people so it requires more trust and you have to work a bit harder to get that connection ... that constant rejection of not turning up you know like – I think that wears you down"* (therapist #4). Additionally one therapist described feeling "annoyed" not only with patients' insufficient commitment, but also the large amount of work and effort that goes behind the plans yet not carried out. *"One around frustrating by not attending group it was at time kind of questioning their commitment to the group... so I felt frustrated that they're not committed within themselves. I personally you know got annoyed that there was so much work that was put into place by <sup>19</sup>XXX and I, and they have not come and they wrecked our plans for the group"* (therapist #7). Another group therapist perceived patients within the group to respond differentially between her and her co-facilitator. She described feeling constantly rejected and dismissed

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<sup>19</sup> Name of co-therapist – referring to therapist #8

during each group session and perceived that patients attached more to the co-facilitator. *“Hasn’t been a pleasant experience but whenever the other group members – and this is sort of like part of the split is was very difficult was quite rejecting sort of dismissive of me but very looking to attach and be with the second therapist”* (therapist #5).

#### A2. Levels of confidence in managing the group change with time

Three group therapists recognised that their confidence levels increase as the course of therapy progressed. Facilitators in the Group ST condition described that their need for supervision acted as a marker of their growth and confidence in managing the group. They noticed a shift from wanting as much supervision as possible to no longer needing it. The need for discussing issues that arise within the group also developed to a “want” to showing group supervisors how they have been going with the group. *“At the beginning stages... we desperately need supervision to give us feedback to go yeah you are doing right. That is right, I think we both needed that... we developed as clinicians in the sense of not needing the desperation of supervision anymore... I think it was really symbolic of our growth of being confident in what we were doing.... I think the first six months was a desperation, “let’s speak to Joan and Ida”. I think the six months after that the desperation was not there at all... It would me more of wow we really want to show you how we have been going, as opposed to we need something from you”* (therapist #7). One group therapist in the Combination condition became more comfortable with time in terms of being playful and silly with group members. *“I’m probably more self-confident in a way and maybe a bit more playful...related to keeping the energy going is you know doing different things to connect and to sort of be a bit silly – yeah*

*different activities really and just to keep the connection yeah I think so probably a bit more playful” (therapist #5).*

### **6.2.2 B. Factors to consider for productive schema group**

Schema therapists identified variables that need to be taken into consideration for the group to be productive. Necessary therapeutic ingredients (e.g. cohesive relationship between co-facilitators, sense of connection among group members) and potential risks (e.g. inadequate resources) were specified, as presented below.

#### **B1. Relationship and dynamics between co-facilitators**

Both pairs of co-therapists endorsed the importance of a supportive and complementary relationship between co-facilitators. Two therapists stated that trust in the co-facilitator was “paramount”. Where there is insufficient trust between co-facilitators, one therapist expressed the possible need to manage the relationship with the other rather than pay full attention to what goes on within the group. Because group has the potential to conjure emotions and personal issues within them, it is therefore essential to trust the co-facilitator’s ability in managing patients within the group. *“Facilitating the group with somebody that you can trust and can hold it is really really important... I just think the trust and respect has to be there for the other clinician. I think if you’re working with somebody that you don’t have that trust in, you’re going to be too busy managing that relationship as opposed to what’s happening in group. At any time, if I’m not traveling so well, in group I know that <sup>20</sup>YYY can take*

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<sup>20</sup> Name of co-therapist – referring to therapist #7

*over... as well as hold the group, she can hold me if something happens... If you don't have somebody that you can trust and that can take over and manage the group while you're pulling yourself together, you could possibly do some damage to clients within there"* (therapist #8). Group therapists found it more advantageous to work with a co-facilitator with whom they understand and understands them well. In this sense, they are aware of each other's "signs and signals" during group. *"If I am feeling vulnerable I feel that it is important that I share that with <sup>21</sup>XXX being the other facilitator, so that one, it's a responsibility of myself saying I am feeling really vulnerable, I'm really mindful of that... And not to babysit me but that is where I am at, at the moment, just so that you know where each other is at"* (therapist #7).

## B2. Risk of deterioration as a result of group participation

Three group therapists expressed concerns surrounding the potential for some patients to deteriorate from group schema participation. Group therapists in the Combination ST condition found that patients who were not ready to face difficult issues or did not have adequate resources to help keep them safe and contained are at risk of deterioration. They articulated that patients would benefit more if they had some basic knowledge of skills prior to starting ST. Because ST works at a deeper level, it can be emotionally confronting and equipping patients with skills may better prepare them for schema work. *"One of the reasons why we've struggled particularly with this group because they don't have the necessary skills to take the schema therapy and use it... probably been too emotionally exposing and I don't know they were necessarily*

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<sup>21</sup> Name of co-therapist – referring to therapist #8



*ready for what group schema therapy requires of them... could have done with some preparation before they had come some group therapy preparation some basic containment and emotion regulation skills before coming to group”*

(therapist #4). Another group therapist described that group members’ sense of safety can be compromised in the presence of group members who have problems controlling their anger. *“There is some people I would not put in a group that I am working with individually now, that I would not suggest schema mode therapy in a group form because I do not think it would be safe for them or the group members. So I am thinking of two at the moment, that I am working with that have borderline personality disorder, but have a strong history around anger and have had <sup>22</sup>VROs placed against them by family members and easily triggered. So if someone looks at them wrong or makes a remark they are very sensitive to interpret that as being derogatory or judgmental, even though schema is fantastic individually for them, I would not suggest group for those people who really struggle with anger, maybe a lot down the track”* (therapist #7).

### B3. Sense of group-mindedness among others with similar experiences

Three therapists regarded the group component of ST as valuable for patients in presenting the opportunity to interact with like-minded individuals with similar issues in their life. This enables patients to be less fixated on their own problems and learn that they are not the only ones going through such difficulties. *“It lets them see that there’re other people like them people with*

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<sup>22</sup> Violence Restraining Order

*say you know, group minded as you will and that they're not the only one with problems in their life" (therapist #6).*

#### B4. Debrief after each group therapy session

Two therapists valued the debriefing at the end of each group session. They described the importance of feedback on issues that the co-facilitator may have missed and addressing any errors they felt they committed and discuss how things could be done differently in future sessions. *"Again, that's where<sup>23</sup>YYY's been really important is with that debriefing and questioning. I think that if we pick up errors with one another, we're able to fix that within the group immediately... Again, cause we trust one another" (therapist #8).*

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<sup>23</sup> Name of co-therapist – referring to therapist #7

### **Chapter Seven: Discussion – Therapist Participants**

In addition to patients' perceptions, this research aimed to gain an understanding of therapists' experiences of working with BPD patients within the Schema framework. Present findings relating to individual and group schema therapists' experiences clearly reflected positive feelings toward the overall process, owing to the observed advancements/improvements made by patients in therapy and therapists' own development in personal and professional areas of their lives. As a direct result of delivering ST, the majority of group and individual therapists described being more cognisant of and better at identifying their own modes and triggers. Therapists found this increased understanding and awareness valuable in regulating their reactions rather than getting caught up in the distressing events/emotions. Current findings also reflect the significant impact that ST has on therapists' own clinical practice outside of the study. Regardless of whether or not therapists were actively practising schema therapy prior to the study, not only were they all applying aspects learnt through delivering ST (e.g. experiential techniques, schema mode conceptualisation, focus on emotional connection), the majority identified more as schema therapists as opposed to previous therapy approaches.

Therapists' perspectives of the Schema model as compared to previous therapy experiences (e.g. CBT, DBT) indicate the need for deeper work (i.e. looking beyond symptomatic profiles/presenting problems), greater focus on process issues (i.e. here-and-now) and more personal involvement from therapists (i.e. flexibility of one's boundaries). These themes generally reflect the unpredictable nature of each session and having to respond accordingly in the moment without feeling fully prepared. Present findings indicating the use

of personal disclosure in therapy and providing contact outside office hours reflect therapists' personal investment and commitment to meeting patients' core emotional needs. For these reasons, while the schema protocol may present as challenging for therapists in this study, the depth with which the schema model facilitates a stronger (and deeper) connection (and relationship) between patients and therapists, as evidenced by the occasional ruptures and subsequent reparation of the patient-therapist bond in therapy. The findings are consistent with a recent study that aimed to distinguish clinician's perceptions among three therapy orientations: cognitive-behavioural, schema-focused and psychodynamic approaches (Boterhoven De Haan & Lee, 2014). Ratings provided by 48 clinicians on the Psychotherapy Process Q-Set (PQS) revealed greater emotional involvement and a stronger interpersonal therapy relationship in the schema-focused approach compared to CBT or psychodynamic conditions (Boterhoven De Haan & Lee). Therapists in this study were clearly affectively involved and committed to meeting patients' needs and improving their well being. It is therefore conceivable that when patients made observable shifts, not only do therapists experience the schema therapy process particularly rewarding and worthwhile; they also became convinced that the schema model is effective.

In terms of working with the borderline population, current findings relating to therapists' feelings of frustration, inadequacy and anxiety in response to behaviours that are difficult to manage portrayed by BPD patients lend support to the consistent theme in the literature that described such behaviours and clinicians' negative attitudes toward this population (Commons Treloar, 2009; Deans & Meocevic, 2006). Therapists expressed difficulties

being at the receiving end of patients' intense anger and detachment; while these emotions and behaviours indicate the borderline modes (i.e. the angry child, detached protector) as described in Arntz et al. (2005), they also reflect the extent to which they evoke within clinicians strong uncomfortable feelings that are difficult to contain (Common Treloar; Psychodynamic Diagnostic Manual [PDM] Task Force, 2006). This may be explained by the "chaotic" nature of the borderline personality structure (Commons Treloar), including common defences employed such as <sup>24</sup>splitting (PDM Task Force).

Additionally, therapists' perceptions of therapy-interfering behaviours displayed by BPD patients in this study including poor attendance and commitment levels were consistent with clinicians' interactions with BPD within the literature (Stone, 2000; Linehan, 1993a). These aforementioned factors certainly contribute to the difficulty in achieving successful therapy outcomes. Therapists in the current study had at least 10 years of therapy experience and are well informed of and accustomed to working with the borderline population. Yet the novelty and extent to which some situations/incidents were difficult to manage (e.g. in the presence of patients' anger) could suggest a high severity level associated with this particular borderline group or techniques specific to the schema model that permit/evoke intense conflicts/emotions in the group or a combination of both factors.

### **7.1 Components of the Schema Model perceived as Therapeutic for Patients**

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<sup>24</sup> Splitting is the tendency to view oneself and others dichotomously in either all-good or all-bad categories; in an idealised or derogatory fashion, or flipping from one to the other.

First, therapists' perceptions that insight can create cognitive and behavioural changes were consistent with various theoretical approaches in psychotherapy particularly in the analytic literature, where insight is regarded as the central agent of change. Current findings found that patients' insight toward the origins of their difficulties contributed to increased recognition of their limitations in the past and reduced self-blame, which subsequently led to behavioural change (e.g. better at dealing with interpersonal relationships). The concept of insight has been described as increased awareness of an individual's mental state and origins of difficulties, leading to new understandings of those events (Moro, Avdibegović & Nemčić Moro, 2012). Hoffart et al. (2002) examined the impact of patients' self-understanding on schema belief and emotional distress in 35 patients diagnosed with panic disorder and/or agoraphobia and cluster C personality traits throughout an 11-week therapy program based on the cognitive model (Clark et al., 1994) and schema-focused approach (Young et al., 2003). Patient ratings revealed that early insight achieved in schema therapy (i.e. first 3 sessions) was significantly correlated with improved therapy outcomes as measured by post-session schema belief and emotional distress (Hoffart et al.).

Second, therapists' narratives regarding the utility of experiential exercises to facilitate understanding through affective experiences were supported by past research. The concepts "hot" or emotionally laden cognitions and "cold" or logical, non-emotional cognitions are well embedded within the cognitive literature (Safran & Greenberg, 1982). Thoughts and feelings about past events are usually drawn from "cold" cognitions and while patients may know the meaning of certain concepts or what is needed at an intellectual level,

it is unlikely this understanding gets internalised and translated to an emotional level. In this sense, shifts and changes are more easily achieved in “hot” cognitions, emphasising the need to use vivid reconstructions (e.g. role-plays, dramatisations, imagery rescripting) to convey such messages (Safran & Greenberg). The nature of such experiential techniques allows for an almost immediate access into patients’ feelings and emotions. These experiential techniques are particularly relevant for BPD patients because they have the tendency to “detach” themselves from experiencing the pain arising from their past or maladaptive schemas, therefore choosing to avoid and emotionally withdraw themselves from others (Arntz et al., 2005; Lobbestael et al., 2007). While being somewhat detached serves as a protective mechanism for patients and has been helpful to an extent in their lives, therapists in the present study found it difficult to achieve therapeutic work with patients, therefore impeding the therapy process. Specifically, therapists’ perceptions that supported the use of imagery to modify distressing emotions that accompany patients’ traumatic memories (e.g. speak up for/protect patient from abuser) is consistent with previous research that applied imagery therapeutically and successfully with disorders including personality (Weertman & Arntz, 2007), mood (Wheatley et al., 2007) and anxiety disorders (Wild, Hackmann & Clark, 2007). Young et al. (2003) described this technique as “Type B imagery rescripting”. The mechanisms behind its effectiveness involved the ability to confront unresolved issues and elicit new emotions. In this way, “healthy” reprocessing of the past event can be achieved, which leads to emotional and psychological growth (Holmes, Arntz & Smucker, 2007).

Third, therapists' perceptions that a positive patient-therapist relationship is necessary in schema therapy are reflected in previous studies particularly during initial stages of therapy (Hoffart, Sexton, Nordahl & Stiles, 2005; Spinhoven, Giesen-Bloo, van Dyck, Kooiman & Arntz, 2007). Therapists in this study specifically identified the attributes of a strong patient-therapist relationship, which included their consistency in providing unconditional positive regard and allowing patients to express themselves without fear of damaging the relationship. These were congruent with "limited reparenting" as outlined in the schema therapy protocol (Young et al., 2003). In addition to the importance of gaining insight during the first few therapy sessions, Hoffart et al. (2002) found that greater therapist-patient connection/alliance at the first session facilitated a more open discussion about patients' EMS-related experiences and predicted a significant reduction in the degree of patients' maladaptive beliefs at later phases (Hoffart et al.). Similarly Spinhoven et al. compared the therapeutic alliance between therapists and BPD patients in schema therapy and transference-focused psychotherapy over a three-year period. Results showed that therapeutic alliance was rated higher in schema therapy and that a higher quality of therapeutic alliance during the first three months of treatment was predictive of lower treatment termination rates and reduced BPD symptomatology (Spinhoven et al.). Taken together, not only is the therapist-patient alliance in schema therapy important in increasing a patient's feelings of safety to freely express schema-related thoughts and emotions, the alliance formed during early phases of therapy would decrease treatment non-compliance and more likely facilitate positive therapy outcomes (e.g. reduction of BPD symptomatology).



Fourth, therapists' views supporting the use of humour as a gateway for creating a non-threatening environment while facilitating permission to be playful in therapy is partially consistent with previous research. A study examining the attitudes of 89 psychotherapists regarding the use of humour in therapy found mixed opinions; half the sample supported the role of humour in therapy whereas the other half rated that humour has a limited place in therapy (Bloch & McNab, 1987). These psychotherapists were of various therapy orientations including analytic, existential, behavioural and problem-solving. On one hand, humour can not only be misunderstood by patients, it may also be used as a defence (e.g. avoidance) against difficult issues that arise (Bloch & McNab). On the other hand, humour has been rated as instrumental in allowing clients to express their emotions in a safe way and alleviating tension/discomfort in session, which may be unproductive and hinder therapy progress (Bloch & McNab). In DBT, which has been specifically manualised for borderline personality disorder, humour and irreverence are employed as a means of communication when therapy becomes "stuck" (Linehan, 1993). Irreverence is commonly referred in the literature as the "judicious use of humour" (Palmer 2002; Slee, Arensman, Garnefski, & Spinhoven, 2007) and is usually practised/applied with the intention of creating an imbalance within the patient (i.e. responding opposite to what the patient is used to). For example, the therapist responds in a dramatic (aloof) manner if patient presents as unemotional (emotional). In this sense, it may be useful to incorporate humour and playfulness into the schema model, provided they are delivered appropriately (e.g. not in a mean-spirited way) with consideration of possible effects on the patients.

Therapists' perceived benefits of a flexible session structure/agenda were partially supported by Owen and Hilsenroth's (2014) study that demonstrated therapist flexibility within the use of a prescribed therapy model (i.e. psychodynamic treatment model) was related to better therapy outcomes (i.e. improved scores on Global Severity Index). Consistent with the context-responsive psychotherapy framework (Constantino, Boswell, Bernecker & Castonguay, 2013), ensuring adequate coverage of the schema content flexibility of the session structure (i.e. therapist flexibility within a treatment model) afforded space for patients to bring up their agendas, which communicates to them the importance of what they have to say.

Additionally the finding that identified therapist self-awareness as important in ensuring personal issues do not interfere with therapy is consistent with previous research (Fauth & Williams, 2005; Gelso & Hayes, 1998; Haarhoff, 2006). Therapist self-awareness refers to the therapist's ability to identify and reflect upon his or her own beliefs and assumptions that may be triggered during the therapy process (Haarhoff). Fauth and Williams examined the relationship between in-session self-awareness of 17 therapists as measured by the In-Session Self-Awareness Scale (ISSA) and client reactions as measured by Helpfulness Rating Scale (HRS), Client Reactions System (CRS) and the Session Impacts Scale (SIS). Both therapists and clients rated therapists' in-session self-awareness as helpful; therapists tended to be more engaged throughout the session while clients experienced a greater level of support and closeness to therapists. Similarly in ST Young et al. (2003) recommended that therapists be aware of their own schemas and modes so that any clashes in schemas between patient (e.g. overcompensation through

entitlement schema and becomes overly demanding) and therapist (e.g. avoidance through subjugation schema and becomes withdrawn) can be identified and managed. In this way troubles in the therapeutic relationship can be minimised or circumvented.

## **7.2 Impressions of ST Training and Supervision**

In a similar vein, findings of this study reflect the value of experiential exercises utilised during schema training, where learning took place not only through practice and receiving immediate feedback during role-plays but also from insight gained by being in the patient's position during therapy. These findings support a study conducted by Bamelis and colleagues (2013), which investigated the effects of therapist training either by lecture and video demonstrations or exercise-based training (e.g. role-play) on treatment outcomes among patients with personality disorders. It was found that the use of experiential techniques during training is superior to lecture-based training in predicting therapy outcomes including lower dropouts, better recovery, global functioning and lower self-ideal discrepancy (Bamelis et al.). Therapists in the current study also recalled feelings of inspiration and enthusiasm during schema training conducted approximately three years prior, suggesting its sizeable impact on therapists.

The intensity of working with the BPD population within a schema model in the present study underscores the need for adequate supervision. Present findings revealed half of the individual therapists at one site experienced inadequate space to discuss their respective patients during their weekly group supervision comprising six therapists. According to the

International Society of Schema Therapy (ISST) for standard Individual Schema Therapy certification, a minimum of 20 supervision sessions of approximately 60 minutes each, together with minimum 15 hours of supervised role-playing in dyads were proposed. While self-therapy was not compulsory, it is “highly recommended” that therapists in training have their own therapy (ISST Board Executive, 2013). For standard level Group Schema Therapy certification, the ISST Board Executive proposed for 20 hours of supervision in Group ST based on 20 group sessions, in addition to four hours of self-therapy over a one-year treatment period. In light of these standards and guidelines, even though it was helpful for individual and group schema therapists in this study to attend group supervision and be aware and informed of their own patients within individual and group settings, duration of the shared group supervision may be too short and insufficient in addressing issues that arise particularly in the individual setting. Given that the present study commenced before the aforementioned guidelines were established, current findings are generally in support of these requirements; however suggest making further provisions for optional one-on-one guidance for those who are new in schema therapy and supervision conducted in a group with more than five therapists.

### **7.3 Factors Necessary for Schema Group to be Productive**

In facilitating group schema therapy with BPD patients, therapists’ beliefs in the therapeutic value created by being among like-minded individuals with similar experiences have been well supported by past research (Holmes & Kivlighan, 2000; Yalom & Leszcz, 2005;). Yalom and Leszcz coined this experience as “universality” and described that patients tend to think of their problems, distressing thoughts, feelings and impulses as unique. Therefore

learning that they are not alone often provides feelings of relief and normalcy for group members (Holmes & Kivlighan; Yalom & Leszcz). The perception of similarity to others within the group increases the likelihood of sharing/disclosing one's experiences and providing feedback (Tschuschke & Dies), while allowing for conversations with distressing content (Mackenzie, 1997). In particular the vulnerable child within the BPD personality structure rarely experiences the sense of being understood and accepted for who they are (Young et al., 2003). Farrell and Shaw (2012) hypothesised that BPD patients' perceived differences from others contribute to feelings of defectiveness/shame (i.e. that there is something wrong with them) and being rejected/ostracised. By feeling supported by group members with similar experiences, not only will BPD patients develop more accurate views of themselves which provide hope for recovery, more importantly the therapy will foster corrective affective experiences (e.g. acceptance, care) that subsequently results in schema change (Farrell & Shaw).

The importance of a supportive and trusting relationship between co-facilitators is also supported in previous articles based on therapist opinions (Hellwig & Memmott, 1978; Wheelan, 1997; Yalom & Leszcz, 2005). When co-facilitators trust each other's capacity and competency in dealing with group situations, their roles can be assumed as complementary, which can catalyse therapeutic interpersonal transactions in the group (Hellwig & Memmott; MacLennan, 1965). On the other hand when co-facilitators are competitive, group members tended to feel unsettled (Yalom & Leszcz). An empirical article studied the interactions between six pairs of co-therapists eclectic in orientation and the quality of their co-therapy relationship in relation to client outcomes

(Kosch & Reiner, 1984). Quality of the co-therapist relationship was measured by co-therapists rating each other and results showed that components necessary for a good co-therapist relationship included being appreciative of, caring and having empathy for the other (Kosch & Reiner). However trust was not mentioned in the article, which was a salient theme in the present study. One pair of co-therapists regarded the importance of trust not only in each other's ability to manage the group, but also providing the space to attend to and focus on group processes. The co-therapist agreement about therapy sessions makes up the overall relationship between co-therapists and was found to be predictive of client outcome as measured by client's level of self-actualisation (Kosch & Reiner). Present findings also revealed that group therapists' perceptions of feeling comfortable and being open with the co-facilitator can ensure a smoother group operation by for example, providing each other constructive feedback and bringing to attention errors made during the debrief after each group session. Despite some differences between findings from previous research and the present study, the co-therapist interaction is nonetheless crucial in facilitating better group outcomes.

Some therapists' reported that patients who did not have adequate resources or resilience to keep them safe within the group were likely to deteriorate is consistent with earlier research. Lieberman and colleagues (1973) defined such individuals as casualties; those who became more psychologically distressed as a result of group participation. The term deterioration has been described in the literature as negative effect, that is to say, a lasting (as opposed to transient) change in an individual's functioning as a direct result of treatment (Strupp, Hadley & Gomes-Schwartz, 1977). Patient characteristics that have

been linked to functional decline or group drop out, as suggested in other research include individuals with a high level of psychological disturbance, low levels of distress/frustration tolerance and difficulties forming relationships with group members. They tended to have personality disorder psychopathology, particularly borderline, narcissistic and schizoid symptomatology (Lieberman et al.; Roback, 2000). Similarly in this study, therapists found borderline patients to be very sensitive to casual, benign remarks made by others. It can be very delicate to facilitate group schema therapy where all members have a primary diagnosis of borderline personality disorder; individuals who struggle with anger can potentially trigger and be a risk factor for inflicting psychological injury to vulnerable/fragile group members.

#### **7.4 Study Strengths**

There are several strengths that exist in this study. Firstly, the researcher was independent of and had no personal investment in the schema program that could influence the interview data. Secondly, the researcher also has not conducted schema therapy, which frees the researcher of potential biases for or against the schema model. That is to say, interview data is largely reflective of therapists' experiences with minimal researcher influence in the interpretation of data. Thirdly, all therapists had the opportunity to correct any misinterpretation by means of an informant feedback. Fourthly, credibility of conclusions drawn about the delivery of schema therapy was ensured; therapist fidelity to the schema protocol has been satisfied by regular checks conducted by the study group, verified by audio and video recordings during individual and group therapy sessions. Lastly, therapists in this study have provided

honest accounts of their negative experiences (e.g. anger, frustration) and perceived faults and flaws of ST, which indicated it was unlikely they responded in a socially desirable manner. Therefore positive experiences (e.g. rewarding, awesome) reported were likely to be considered trustworthy and reliable.

### **7.5 Limitations**

Considering the small sample size in this study, it is unlikely that data saturation had been achieved. Findings may be influenced by the idiosyncrasies of each individual and were only specific to therapists within the two Perth sites. While the study results may not generalise to the wider clinical population, findings can be transferable where congruent themes will most likely emerge with similar populations (i.e. therapists working with patients with a diagnosis of borderline personality disorder within the schema model in group and individual settings). Therapists in the sample also volunteered for the schema program whereas those who had doubts or did not believe ST to be beneficial were unlikely to commit to this intensive program. Therefore study results may represent a slightly more optimistic sample.

### **7.6 Clinical Implications and Conclusion**

Limitations notwithstanding, it appeared that research findings included not only therapists' positive, but also negative experiences in delivering ST to patients with BPD. These research findings have significant clinical implications for mental health practitioners, and existing and planned mental health policies. The highly endorsed items reflect areas of importance to therapists, which may not only inform the theoretical model of schema therapy,



but also what to be mindful of when conducting schema therapy with borderline patients. These include:

1. Therapists' largely positive experiences (i.e. personal and professional gains) in delivering ST and observed improvements made by patients reinforces the utility of the schema model with the BPD population.
2. Depending on therapists' previous therapy experiences or approaches they are familiar with, it may be beneficial for those interested in conducting ST be aware that sessions can be unpredictable and spontaneous, and therefore be prepared to respond in the moment.
3. On a similar vein, future therapists may need to be more flexible with their boundaries when working within the schema model. For example, appropriate use of therapist self-disclosure and being more transparent/real/candid in therapy rather than always maintaining a more distant professional stance may be necessary in achieving therapeutic outcomes.
4. It was apparent that therapists were affectively involved during the process of delivering ST and a strong therapist-patient bond cannot be understated especially during the early phases of ST given that a) "Limited re-parenting" is a key feature of ST, b) High dropout rates are commonly associated with borderline personality disorder (Kelly et al., 1992; Waldinger & Gunderson, 1984), and c) Therapeutic alliance at the first session predicted a significant reduction in patients' maladaptive beliefs (Spinhoven et al., 2007).
5. Therapists' experienced frustration and difficulties in achieving successful treatment outcomes in response to non-attendance. Perhaps

this could be managed by adopting strategies common to DBT. For example the DBT terms of contract specify that patients give at least 24 hours notice were they unable to attend and that therapy be terminated until further negotiation should they miss four consecutive sessions (Linehan, 1993). It may also be of value for group facilitators to take the time to explain the power of and common emotional responses (e.g. feeling overwhelmed and subsequent avoidance) that follow experiential work as and when necessary as the therapy progresses.

6. The value of insight informs the continued use of techniques embedded within the schema model (e.g. psychoeducation of schema modes, role-playing) in facilitating patients' self-understanding particularly during early phases of schema therapy.
7. The utility of experiential techniques, which facilitate an emotional understanding subsequent to an intellectual one, encourages their use within the model particularly when BPD patients are in the detached protector mode.
8. Therapist and patient's schema modes can reinforce one another, negatively impacting on the therapeutic relationship and leading to undesired therapy outcomes. It may be worthwhile for therapists to understand their own modes and be aware when they are activated during therapy.
9. Due to the nature of the schema model in conjuring up emotions within therapists, it is important, when running group schema therapy to consider a co-facilitator that one trusts and is comfortable with. This would encourage open communication and is likely to reduce the

pressure of managing any unspoken issues between co-therapists while increasing quality of therapy delivered.

10. Running groups with BPD patients within a schema model can certainly be frustrating and anxiety provoking at times, however the finding that group therapists' confidence levels increase with time provides assurance to future group schema therapists and is indicative of therapist growth in terms of experience and skills.
11. Group schema therapy has been perceived as confronting and emotionally exposing for patients with BPD and group therapists have raised concerns about how such patients may be impacted and how they may impact others within the group. These individuals are psychologically brittle and tend to have an unstable and fragmented sense of self (Young et al., 2003). In such cases, it would be of benefit to look out for and provide individuals who are particularly vulnerable (e.g. highly reactive and prone to anger outbursts with limited emotion regulation skills, not ready to deal with past trauma) with some basic skills and/or extra support alongside group ST (e.g. provision of additional/more intensive individual ST sessions) to maintain safety and cohesion within the group. While the current study screened out BPD patients with traits of antisocial personality disorder, it may also be helpful excluding patients who struggle with intense anger and hostility particularly if anger interferes with other members benefitting from the group. Perhaps it would be useful, pre-therapy to administer a measure of hostility such as the Buss-Durkee Hostility Inventory, which has been shown to predict behaviours in BPD (Ferraz et al., 2013). Alternatively,

a structured interview for hostility (e.g. Structured Interview Potential for Hostility Scale) could be used as such inventories display a higher predictive power as compared to self-report measures (Miller, Smith, Turner, Guijarro & Hallet, 1996).

12. Therapists' narratives regarding the learning value of experiential methods of training support the continued use of experiential techniques in schema training.
13. The intensity of working with borderline patients especially within a Schema model requires ongoing supervision/consultation and support for therapists. While it is helpful for individual and group therapists to participate in supervision together in allowing group therapists to understand the personal struggles of each patient and individual therapists to observe how their respective patients interact within a group setting, it appeared that providing some structure (e.g. allocate a fixed time duration for each schema therapist, having an agenda at the beginning of supervision) could lead to a more even distribution of time and space to seek support and discuss difficulties faced with their patients.

This study provides valuable insight into therapists' experiences when delivering schema therapy to individuals with borderline personality disorder. Therapists' broad experiences indicated the sense of reward that accompanied positive gains made by patients, the benefit of working beyond patients' symptomatic profiles, the capacity for therapist-patient dynamics to evoke strong emotions and the need for experiential-based training and regular supervision. Distinctive group processes in facilitating an operative/productive

schema group included a supportive relationship between co-therapists, compatibility among group members in fostering a sense of commonality/similarity while looking out for potential individuals at risk of afflicting and those particularly vulnerable to psychological injury. The process of delivering schema therapy has an inadvertent impact on therapists' professional and personal lives, and aforementioned areas of salience will no doubt enhance existing understandings of the schema model and inform more efficient delivery to individuals with borderline personality disorder in the future.

### **Chapter Eight: Overall Discussion and Conclusion**

The present study had several aims. Previous chapters have outlined how specific aspects of ST and non-specific therapeutic aspects have facilitated gains made by patients as well as the personal and professional impact ST had on therapists. Patients' and therapists' perceptions of group processes present within group ST have also been discussed separately. This chapter will explore any concordance and clarify differences between patients' and therapists' experiences of ST.

Both patient and therapist groups agreed on the therapeutic value of several components of the schema model. First, the utility of experiential techniques was unanimous where patients and therapists stressed the benefits of adding an emotional level of understanding to an intellectual one. However there were differences in the extent to when patients and therapists perceived ST facilitated emotional reprocessing; while therapists found experiential techniques helped facilitate an immediate access to patients' emotions, patients indicated this process as confronting given that they had spent large amounts of time in the past suppressing and avoiding painful memories. Even though it was helpful for patients to work through such memories and getting in touch with the vulnerable parts of themselves to make sense of current situations, they did not particularly enjoy the process at that time. It was not until they noticed themselves coping better through making cognitive and behavioural changes before its benefits were appreciated.

Second, there was consensus regarding the extent to which ST provided insight and facilitated self-understanding particularly knowledge acquired

through schema concepts and the mode model. Specifically patients reported that the mode model provided a logical way of thinking which helped make sense of certain situations. On the other hand therapists reported how the schema terminology provided a language that is not only easy for patients to understand but also useful in naming and helping patients express their needs. Therapists also reported that the model helped them understand themselves better when working with patients and in other emotional contacts of their personal life.

The third area of concordance between patients and therapists was the importance of a strong therapist-patient alliance. From patients' perspectives, the emotional connection and extent to which they felt supported and held through therapists' personal disclosure, non-judgmental attitudes and attentiveness to their needs were key to a positive therapist-patient relationship. While these elements of a positive therapist-patient relationship could be due to therapists' personalities and preferred working style, it appeared from therapists' perspectives that their approach to therapy was very much guided by the principles and theoretical underpinnings outlined in ST (e.g. providing limited reparenting). These principles specific to ST were carried out despite some being novel and unfamiliar to therapists based on their previous clinical experiences (e.g. the use of therapist self-disclosure in ST as opposed to maintaining a strict professional boundary or "blank screen" as in other therapies, the need to stay with where the patient is at in ST as opposed to the tendency to problem-solve as in other therapies).

Another effective component of ST emphasised by both patients and therapists was the provision of space within the therapy model for patients' to

talk about what was on their minds. Therapists' narratives considered the significance of patients' needs while applying/integrating the schema model to whatever was brought in to the sessions. Conversely pressing on with prescribed content of the schema model would not only fail to validate patients' experiences but would also be counterproductive to the message (i.e. patients' needs are important) ST aimed to communicate to patients. The prioritisation of patients' agendas was verified by patients' experiences of being allowed to deviate from the planned session structure and speak their minds during therapy.

Additionally both patients and therapists appreciated the complementary nature of group and individual ST where each therapy format contributed unique benefits (e.g. fostering connection among like-minded individuals in the group component, personal focus in the individual component). One therapeutic group factor not specific to ST shared by patients and therapists involved the sense of connection among group members (i.e. universality) created by learning that they were not alone in their problems and distress. Patients' perceptions of other therapeutic elements that were not specific to the schema model appeared to arise from group therapy, some of which referred to as "change catalysing factors" in Farrell and Shaw (2012). Having said that, the relationship with group therapists could underlie and contribute to such positive experiences. For example, the therapeutic relationship between group therapists and patients allowing patients to feel safe enough to share and express their feelings and emotions.

It was of interest to note the differential feelings majority of patients in the Combination condition held toward their group therapists. The idealising of



one therapist while devaluing the other could represent the defense mechanism of splitting, a characteristic often associated with borderline pathology (Perry & Cooper, 1986). Despite having over 15 years of group therapy experience, both group therapists in the Combination condition found this group particularly difficult to manage due to the lack of adequate resources to keep patients safe and contained. Relationship ruptures within this group have left two members no longer feeling safe enough to fully participate (e.g. present in group but feeling detached, skipping or not turning up for group sessions). While this phenomenon could reflect the intensity of GST for BPD patients, it could also signify the difficulty of and skills needed for effective conflict management with this population. When comparing group therapists between the two sites/conditions, group therapists in the Combination condition did not work primarily from the main facility where group therapy was conducted and where individual therapists were based. The situation was less than ideal and logistical problems arose including the lack of sufficient communication between individual and group therapists. Debrief was also done during the traveling time to and from the facility. It appeared that logistical issues have played a role in group therapists' perceived difficulty to manage the group of already vulnerable patients. Furthermore comparing patients between the two sites/conditions, given that positive descriptors of the group experience (e.g. comradeship, chain-link) were used in relation only to the Group ST condition, it is conceivable/plausible that therapists playing the dual role of individual and group schema therapists could have eliminated any communication and logistical problems, contributing to more efficient management of the group. It may also be worthwhile for co-therapists to explore the dynamics and schema

interactions between them (e.g. competitiveness between group facilitators can be addressed through exercises that increase awareness of their own schemas). Additionally the discussion of schemas getting triggered between group therapists could form a central focus for the ongoing supervision process.

### **8.1 Implications and Recommendations for Future Research**

The aim of this study was to explore BPD patients' and therapists' experiences of receiving and providing schema therapy respectively. One of the questions that emerged from current findings was the extent to which the existing schema protocol supported patients' recovery from BPD. It was of interest to note that reported gains made by patients were largely not described in terms of symptom reduction, rather they represented improvements in the wider personality structure (e.g. becoming more in touch with their emotions, increased ability to assert/stand up for oneself). It was clear from patients' and therapists' narratives that ST, without directly targeting borderline symptoms and by correcting maladaptive schemas formed from early childhood experiences, led to improvements that extended beyond symptom reduction. That is to say therapeutic benefits were ancillary to symptom reduction but no less significant. This phenomenon is not dissimilar to the concept of "linchpin" factors where the identification and subsequent target of core issues/problem source can lead to beneficial "ripple" effects on affected areas of one's life (Restifo, 2010).

The finding that skills acquired during schema therapy facilitated achievement of broader personal goals such as asserting and standing up for oneself contrasts with a qualitative study (Perseus et al., 2003) that explored

BPD patients' experiences of receiving DBT. Perseius and colleagues (2003) reported on the utility of skill provision however only in overcoming suicidal and self-harming impulses. This is interesting given that DBT was the predominant specialist psychotherapy received by <sup>25</sup>study patients prior to the schema program. According to a review of RCT's on DBT, a strong emphasis is placed on reducing self-harming behaviours (Lynch, Trost, Salsman, & Linehan, 2007). The authors also described other phases of DBT which focused on practical skills training contingent on the condition that self-injurious behaviours have been resolved (Lynch et al., 2007). A prescribed focus on specified domains runs the risk of overlooking other personal goals (Katsakou et al., 2012). In comparison to DBT, while study patients undergoing ST appeared to make more holistic therapeutic progress, further research needs to explore whether these gains are maintained and for how long.

Another more specific question was whether there was a need to adjust the existing schema protocol for BPD patients. Patients' expressed dissatisfaction towards the duration and end of ST. Therefore it appears that there is a need to address concerns regarding treatment termination within the schema model. Treatment termination is often challenging and tended to involve some form of mourning and possible resurfacing of abandonment fears in BPD patients (Arntz & Van Genderen, 2009). Therapy sessions offered by public mental health services are often limited and unlikely to extend over two years. It is therefore essential for future research to incorporate clear guidelines on when and how to address concerns regarding therapy termination within the schema framework.

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<sup>25</sup> Patients mainly received DBT and CBT previously

It would also be of benefit to explore patients' subjective interpretations of recovery from BPD. In Katsakou et al.'s (2012) study, some service users found the term "recovery" problematic, being perceived as an all or nothing concept. This definition is unhelpful as it can set patients up for frustration or disappointment by creating unrealistic expectations of therapy (Katsakou et al., 2012). Whilst some patients may not meet diagnostic criteria for BPD after treatment, complete elimination of symptoms is uncommon. A few BPD patients in this study felt disappointed with themselves for not improving "fast enough". A clarification of their personal goals or viewpoints of recovery from BPD at some point during ST could help negotiate a better fit between patients' personal goals and ST aims. This could potentially lead to greater acceptance so that patients become less hard on themselves particularly when approaching termination. Recovery from BPD as assessed by various assessment tools (e.g. borderline personality disorder severity index [BPDSI], Structured Clinical Interview for DSM Axis II Personality Disorders [SCID-II]) often focus only on symptom improvements. However it was evident from current findings that progress or changes made were not necessarily limited to prescribed criteria listed on established assessment tools. In fact service users' perspectives of recovery from BPD can be represented in many different forms (Katsakou et al.). Future research could further clarify what constitutes recovery from BPD to create a more accurate representation in addition to symptom improvements.

In relation to group therapy, the inevitable conflicts that occur during group ST demands the need for a strong sense of safety in the group for patients to openly express themselves. This calls for a balance between potential screening of patient characteristics (e.g. those scoring high on hostility, those

with poor coping skills) and group facilitators' ability and responsibility to manage conflicts as a team. Future research could point toward exploring the effects of training group schema therapists to better manage conflicts within the group; where therapists in the control condition would follow standard schema therapy training protocol whereas therapists in the experimental condition could have a stronger focus on managing group dynamics. Group therapists' competencies can then be rated (e.g. Group Schema Therapy Competency Rating Scale) by an independent observer in both conditions.

Additionally the capacity for group ST to be confronting and difficult for patients indicate the need to address the suitability of group members and how group ST may adapt to group members' needs. While DBT endeavours to increase patients' coping skills (Lynch et al., 2007), ST places a greater focus on safety within the group (Young et al., 2003). It could be of value to explore if the group component of ST should focus more on providing adaptive coping skills compromising the sense of safety within the group or continue to prioritise a high sense of safety therefore not requiring a large focus on provision of skills. More specifically group members could complete measures (e.g. DBT-Ways of Coping Checklist [DBT-WCCL]) during the initial assessment phase that evaluate their coping skills. Those scoring high on adaptive skills and those scoring high on dysfunctional coping could be allocated to separate groups run by the same group schema therapists. Perceived difficulties with group management can then be explored qualitatively through therapist interviews and quantitatively through questionnaires completed by group members (e.g. Intragroup Conflict Scale, Group Cohesion Scale). Treatment outcomes within the schema group can also

be assessed through various self-report measures over various time points throughout the course of therapy.

## **8.2 Final Conclusion**

To my knowledge this is the first study to investigate experience of schema therapy for BPD informed by therapists' and patients' narratives. This inquiry is an initial attempt to understand holistically how various components embedded within the schema framework are experienced by both therapists and patients. Therapeutic aspects mutually agreed upon by patients and therapists included the use of experiential techniques, the extent to which ST provided insight, the therapeutic alliance, space within the schema model for patients' agenda and sense of universality brought by being in the same group among like-minded individuals. Integrated findings also indicated the importance of effective conflict management within group ST and the potential for logistical issues to negatively influence the therapy process.

Study implications included the need to address outstanding concerns (e.g. strengthening cohesiveness within the treatment team) when applying group and individual ST within public mental health settings, develop clearer guidelines in relation to therapy termination and clarifying the concept of recovery from BPD. Current findings suggest future research could consider exploring the interplay between the effects of additional training for group schema therapists and how the level of patient dysfunction within the group has an impact on group therapists' ability to manage conflict. In addition the relationship between provision of skills and safety within the group can be further examined. These findings while exploratory in nature contribute to

current understandings and address limitations of the schema model while enhancing its feasibility and implementation.

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## Appendix A

### Aetiology of Borderline Personality Disorder

#### *Genetics, neurotransmitters, neurobiology*

Genetics	Individuals with a first-degree relative increase the risk of developing symptoms of BPD by three- to four-fold (Gunderson et al., 2011). Twin studies have found that 51% to 75% of the variance is explained genetic factors (Distel et al., 2010; New, Goodman, Triebwasser & Siever, 2008). NCCMH (2009) explained that traits of impulsive aggression, emotional dysregulation and hypersensitivity in relationships were found to run in families (Gunderson et al.).
Neuro-transmitters	It was found that individuals with BPD suffer from reduced serotonergic responsiveness associated with difficulty in managing impulsive urges that may be detrimental to themselves or others (Rinne, Westenberg, den Boer & van der Brink, 2000). Other neurochemical pathways associated with BPD include increased vasopressin levels relating to increased irritability and aggression, an imbalance of neurohormones relating to interpersonal vulnerabilities (Stanley & Siever, 2010), dysregulated hypothalamic-pituitary adrenal (HPA) axis and hypersuppression of cortisol relating to dysfunctional stress responses (Zimmerman & Choi-Kain, 2009).
Neurobiology	According to brain imaging studies, larger pituitary gland volumes are positively related to lifetime frequency of parasuicide acts in teenage BPD patients (Jovev et al., 2008). When compared to the controls, BPD patients have shown significantly greater amygdala activation in response to pictures of facial emotional expressions, implying a hypersensitive amygdala (Donegan et al., 2003). Other structural brain areas associated with BPD include decreased gray matter concentration in areas of the prefrontal cortex (Brunner et al., 2010).

#### *Adverse childhood events*

Abuse	Individuals with BPD tended to report on accounts of physical, sexual and emotional abuse significantly more than healthy controls and those with mood disorders and other personality disorders (Zanarini et al., 2000; Perry & Herman, 1993). It was found that not only have majority of 290 BPD inpatients been sexually abused, but the intensity of reported childhood sexual abuse also directly correlated to the severity of BPD symptoms and psychosocial impairment (Zanarini et al., 2002).
Dysfunctional family environments	Bradley, Jenei and Westen (2005) identified that family environment and parental psychopathology, particularly substance abuse and anxiety disorders play significant roles in the development of BPD. Individuals with BPD often experience a father who is emotionally distant while sharing an antagonistic relationship with their mothers, perceiving them dichotomously as either distant or overprotective (NCCMH, 2009). Furthermore, borderline inpatients have reported inconsistent treatment and denial of their emotions and needs as they were growing up (Zanarini et al., 1997). The rejection and discounting of a child's appraisals of his or her experience can communicate that it is wrong or unnecessary to express such feelings and needs. Likewise, children in over-critical and harsh family environments may internalise their caregivers' negative comments and develop a harsh superego (Sable, 1997).

**Appendix B****Mode groups associated with Borderline Personality Disorder**

Abandoned/Abused child mode	The Abandoned/Abused child mode represents the core emotional state and is characterised by an overwhelming fear of abandonment. The borderline patient in this 'childlike' state feels completely vulnerable and tends to fully rely on the therapist for unconditional validation, support and encouragement (Arntz & van Genderen, 2012).
Angry/Impulsive child mode	When the borderline patient feels frustrated and angry because of unmet core emotional needs, it results in the Angry/Impulsive child mode demanding and expressing that anger in inappropriate ways (e.g. verbally abusive to others) or acting impulsively (e.g. impulsive alcohol binge) in order to attempt to meet those needs (Arntz & van Genderen, 2012). These unreasonable actions usually alienate others as patients push away the people around them (Young et al., 2003).
Punitive Parent	The Punitive Parent reflects the critical voice(s) of one or both parent(s) that the borderline patient internalises (Lobbestael et al., 2007), reflecting a self-punitive state characterised by a harsh and disapproving tone, where patients often condemn themselves and feel that they deserve to be punished (Arntz et al., 2005). This may be expressed by patients' self-loathing tendencies and at times engage in self-destructive behaviours (Arntz & van Genderen, 2012). Even though BPD patients are known for their crisis and verbally aggressive behaviours, it was noted that they tend to be detached during therapy (Arntz et al.).
Detached Protector mode	BPD patients in the Detached Protector mode may detach and 'protect' themselves from experiencing the pain arising from their maladaptive schemas, therefore choosing to avoid and emotionally withdraw themselves from others. In this way, individuals with BPD tend to operate in a mechanical fashion, where they reject help from others and come across as 'cold' (Arntz et al., 2005; Lobbestael et al., 2007). However when they are unable to detach or 'block out' their psychological pain, they may find other means of escape or distraction. As a result, some of the symptoms include substance abuse, feelings of emptiness, dissociation and self-inflicted pain (Arntz & van Genderen, 2012).
Healthy Adult mode	The Healthy Adult mode depicts a healthy developing adult who is capable of appropriate self-expression and taking responsibility in major life functions. Unsurprisingly, this mode is under-developed in borderline patients (Arntz et al., 2005; Lobbestael et al., 2005); they have not developed the ability to tolerate separation and distress (Young et al., 2003).

**Appendix C**

## Inclusion and exclusion criteria

Inclusion	Exclusion
1. Aged 18 to 65 years old	1. Lifetime psychotic disorder (short stress-related episodes are allowed)
2. Primary diagnosis of borderline personality disorder, as assessed by the SCID-II	2. IQ < 80
3. BPD severity score of above 20 on the borderline personality disorder severity index (BPDSI)	3. Inability to read, speak or write in English
4. Willingness and ability to participate for at least 3 years	4. A diagnosis of ADHD, Bipolar Disorder Type 1, Dissociative Identity Disorder (DID), full or sub-threshold narcissistic or antisocial personality disorders
	5. Serious and/or unstable medical illness
	6. Substance dependence needing clinical detox (after detox and 2 months sobriety can be included)
	7. Previous schema therapy of more than 3 months

**Appendix D**



**School of Psychology**

**Information letter for Participants**

**International multi-centre trial of Schema Therapy vs Treatment as Usual  
research study for Borderline Personality Disorder**

Dear XXX,

Thank you for your continued participation in the “International Multi-Centre trial of Schema Therapy vs Treatment as Usual” research study. In addition to the measures that you have completed to date, the purpose of the interview is to seek information about how you found your experience of treatment to date and whether there is anything we can learn from you that might inform future treatments.

You are invited to participate in an interview that will take approximately one hour. A researcher independent to the therapists who are treating you in the study will ask you a series of open questions about your experience of Schema Therapy in the study.

There are no specific risks anticipated in this interview. However, if you find that you are becoming distressed, you will be advised to receive support from your case manager and your individual therapist. At the end of the interview, you will be offered a movie ticket in appreciation of your time and effort.

You can decide at any time to withdraw your consent to participate in this interview. If you decide to withdraw, any material you have given us will be destroyed.

Withdrawing from the interview will not impact in any way on the treatment you receive.

Sincerely,

Dr Christopher Lee

**Appendix E**



**School of Psychology**

**Consent Form for Participants**

**International multi-centre trial of Schema Therapy vs Treatment as Usual  
research study for Borderline Personality Disorder**

I have read the information sheet, which explains the nature of the research. The information has been explained to me and all my questions have been satisfactorily answered. I have been given a copy of the information sheet to keep.

I am happy to be interviewed and for the interview to be audio recorded as part of this research. I understand that I do not have to answer particular questions if I do not want to and that I can refuse or withdraw at any time without needing to give a reason and without consequences to myself.

I agree that research data from the results of the study may be published provided my name or any identifiable information is not used. I have also been informed that I will receive a movie ticket as a form of compensation for the time involved.

I understand that all information provided by me is treated as confidential and will not be released by the researcher to a third party unless required to do so by law.

Participant's name: \_\_\_\_\_

Signature of Participant: \_\_\_\_\_ Date: ...../...../.....

I confirm that I have provided the Information Letter concerning this study to the above participant; I have explained the study and have answered all questions asked of me.

Signature of researcher: \_\_\_\_\_ Date: ...../...../.....

## **Appendix F**

### Interview Questions for Patients

#### **Patients' overall experience of receiving ST**

1. How was your experience of schema therapy?
2. What aspects of therapy have been most helpful?
3. Was there a pivotal moment for you during the course of therapy?
4. If during the course of therapy you started feeling comfortable/wanting to open up, what helped you do so? In the case you felt uncomfortable/shut down, what were the reasons?

#### **Expectations and previous therapy experiences**

1. Prior to treatment, did you think you could change?
2. How are the other therapies you have engaged in differed from schema therapy?

#### **Patient evaluating therapeutic tasks**

1. How were the attitudes of your therapists toward borderline symptoms?
2. How were the topics decided? If you had something important, to what degree you felt you could get attention for it?
3. How do your family members and close friends feel toward your therapy?

#### **Patients evaluating the group experience**

1. How was your experience of group schema therapy?
2. How did you find talking and sharing about your feelings and emotions to other group members?
3. To what extent did you experience discomfort/negative feelings from being a member in the group?
4. How do you think your role in the group affected the group as a whole and interaction within the group?

#### **Patients comparing individual and group experience**

1. Comparing group and individual schema therapy, which do you feel is more beneficial/useful for you?
2. To what extent did you respond differently in group as opposed to individual therapy?
3. How was your experience with the group and individual therapists?
4. To what extent did you feel your needs were met in group and individual therapy?

#### **Final and closing interview questions**

1. Is there anything you would like to change about the program?
2. How did you experience our interview?



**Appendix G**



**School of Psychology**

**Information letter for Therapists**

**International multi-centre trial of Schema Therapy vs Treatment as Usual  
research study for Borderline Personality Disorder**

Dear XXX,

The purpose of this project is to conduct a detailed evaluation of the “International multi-centre trial of Schema Therapy vs Treatment as Usual” research study for Borderline Personality Disorder. We hope to find out whether the intervention is meeting its aims successfully and whether there is anything we can learn from you that will inform future treatments.

You are invited to participate in an interview that will take approximately one hour. We would like to explore your experiences in providing Schema Therapy in this study to date.

While there may be no direct benefit to you from participating in this interview, the knowledge gained from your participation may help with our understanding of the processes involved in Schema Therapy. Also, there are no specific risks anticipated with participation in this interview.

You can decide at any time to withdraw your consent to participate in this interview. If you decide to withdraw, any material you have given us will be destroyed. Withdrawing from the interview will have no consequences for your ongoing participation in delivering Schema Therapy.

Sincerely,

Dr. Christopher Lee

**Appendix H**



**School of Psychology**

**Consent Form for Therapists**

**International multi-centre trial of Schema Therapy vs Treatment as Usual  
research study for Borderline Personality Disorder**

I have read the information sheet, which explains the nature of the research. The information has been explained to me and all my questions have been satisfactorily answered. I have been given a copy of the information sheet to keep.

I am happy to be interviewed and for the interview to be audio recorded as part of this research. I understand that I do not have to answer particular questions if I do not want to and that I can refuse or withdraw at any time without needing to give a reason and without consequences to myself.

I agree that research data from the results of the study may be published provided my name or any identifiable information is not used. I have also been informed that I may not receive any direct benefits from participating in this study.

I understand that all information provided by me is treated as confidential and will not be released by the researcher to a third party unless required to do so by law.

Therapist's name: \_\_\_\_\_

Signature of Therapist: \_\_\_\_\_ Date: ...../...../.....

I confirm that I have provided the Information Letter concerning this study to the above participant; I have explained the study and have answered all questions asked of me.

Signature of researcher: \_\_\_\_\_ Date: ...../...../.....

## **Appendix I**

### Interview Questions for Therapists

#### **Therapists' overall experience of providing ST – individual or/and group**

1. How was your experience conducting schema therapy overall?
2. Have you had any experiences as a therapist during therapy that you would call important?
3. Were there pivotal moments for you as a therapist during the course of therapy?
4. To what extent did you experience difficulties or discomfort during or after the sessions?

#### **Schema training and previous therapy experience**

1. Looking back to your prior training in schema therapy, how well did you feel prepared for the therapy?
2. What aspects of training were most impactful/helpful for you?
3. Do you see any differences to other approaches you know closely or were trained in?
4. From your own experience as a schema therapist, what are the advantages of this approach regarding achievements and what are some shortcomings?

#### **Influence of ST on therapist's life**

1. How have your attitudes changed being a schema therapist?
2. Has conducting schema therapy influenced your professional, personal or social life?

#### **\*Additional questions specific to therapists providing Group ST**

1. How was your experience being a co-therapist in GST?
2. How did you feel within the group and after group sessions?
3. What roles do you think you and your co-facilitator had within the group?
4. Which aspects of GST did you find useful for the patients and yourself as a therapist?
5. Would you say that some patients can be at risk of deteriorating by participating in GST?

#### **\*Additional questions specific to therapists providing both Individual and Group ST**

1. How was your experience being a therapist in individual ST versus Group ST in general?
2. Would you say you react differently as a group facilitator as opposed to an individual therapist?
3. Which combination of group and individual ST would you say is best suited for whom?

#### **Final and closing interview questions**

1. Is there anything you would change about the program (e.g. setting, ground rules)? Would you continue to conduct schema therapy with BPD patients?
2. How did you experience this interview?