Clinical Psychology Review 33 (2013) 426–447

Contents lists available at SciVerse ScienceDirect

Clinical Psychology Review

Schema therapy for borderline personality disorder: A comprehensive review of its empirical foundations, effectiveness and implementation possibilities

Gabriela A. Sempértegui [a,*], Annemiek Karreman [a], Arnoud Arntz [b], Marrie H.J. Bekker [a]

[a] Tilburg University, The Netherlands
[b] Maastricht University, The Netherlands

HIGHLIGHTS

- Offers both theoretical description and empirical review of the schema model for BPD.
- Evidence exists for a number of schema constructs and mechanisms.
- The extant efficacy studies show positive outcomes of schema therapy for BPD.
- Schema therapy seems a societal cost-effective approach.
- Further work is required to achieve full empirical support of the model and therapy.

ARTICLE INFO

Article history:
Received 29 March 2012
Received in revised form 23 November 2012
Accepted 26 November 2012
Available online 4 December 2012

Keywords:
Borderline personality disorder
Schema therapy
Young's schema model
Early maladaptive schema
Schema mode
Effectiveness

ABSTRACT

Borderline personality disorder is a serious psychiatric disorder for which the effectiveness of the current pharmacotherapeutical and psychotherapeutic approaches has shown to be limited. In the last decades, schema therapy has increased in popularity as a treatment of borderline personality disorder; however, systematic evaluation of both effectiveness and empirical evidence for the theoretical background of the therapy is limited. This literature review comprehensively evaluates the current empirical status of schema therapy for borderline personality disorder. We first described the theoretical framework and reviewed its empirical foundations. Next, we examined the evidence regarding effectiveness and implementability. We found evidence for a considerable number of elements of Young's schema model; however, the strength of the results varies and there are also mixed results and some empirical blanks in the theory. The number of studies on effectiveness is small, but reviewed findings suggest that schema therapy is a promising treatment. In Western-European societies, the therapy could be readily implemented as a cost-effective strategy with positive economic consequences.

Contents

Abbreviations: BPD, Borderline personality disorder; ST, Schema therapy; EMS, Early maladaptive schema; TFP, Transference focused psychotherapy; TAU, Treatment as usual; DBT, Dialectical behavior therapy; MBT, Mentalization based therapy; RCT, Randomized controlled trial.

* Corresponding author at: Department of Medical and Clinical Psychology, Tilburg University, P.O. Box 90153, 5000 LE Tilburg, The Netherlands. Tel.: +31 13 466 3294; fax: +31 13 466 2067.
E-mail address: g.a.semperteguivallejo@uvt.nl (G.A. Sempértegui).

0272-7358/$ – see front matter
http://dx.doi.org/10.1016/j.cpr.2012.11.006

1. Introduction

Borderline personality disorder (BPD) is one of the most common (Maier, Lichtermann, Klingler, Heun, & Hallmayer, 1992) serious and challenging psychiatric disorders for both patient and therapist. BPD's core features, including impulsivity, negative affect, problematic relationships, incapacity of controlling intense, fluctuating emotions and lacking sense of self, cause major psychosocial impairment (American Psychiatric Association, 2000). The symptoms of BPD are clustered in two groups: the acute symptoms, including impulsivity, self-injurious and reckless behavior; and the temperamental symptoms, such as poor self esteem, fear of abandonment, distrust, and anger (Zanarini et al., 2007). Patients with BPD often experience crisis episodes, characterized by depression, anxiety, and (para) suicidal and self-injurious behavior, sometimes leading to hospitalization (Van Asselt, Dirksen, Arntz, & Severens, 2007). Substance abuse and other types of self-destructive behavior, like delinquency, unsafe sex and reckless driving might also be salient characteristics (Trull, Sher, Minks-Brown, Durbin, & Burr, 2000), resulting in high rates of (non-)health related costs (American Psychiatric Association, 2001; Van Asselt et al., 2007).

The effectiveness of pharmacotherapy to treat BPD has shown to be limited and mostly based on single study effects (Lieb, Völlm, Rücker, Timmer, & Stoffers, 2010; Stoffers et al., 2010; Zanarini, 2004). Antidepressants and first-generation antipsychotics seem to have some beneficial effects on comorbid psychopathology, whereas second-generation antipsychotics and mood-stabilizers seem to contribute to reduction of affective dysregulation symptoms, and omega-3 fatty acids to reduction of suicidality. Yet none of the afore-mentioned drugs have shown to affect overall BPD severity nor the core symptoms, such as identity disturbance or feeling of emptiness (Stoffers et al., 2010). For this reason, psychotherapy is still the preferred treatment approach (APA, 2001); however, not without great difficulties. For instance, patients with BPD tend to instigate therapists' counter-transference reactions during sessions (Maltsberger & Buie, 1974); they often show retrocession in treatment (Gunderson & Kolb, 1978) and therapy dropout is high (67%; Gunderson et al., 1989). Furthermore, studies examining the efficacy of psychotherapy for BPD are still scarce to allow drawing strong conclusions (Stoffers et al., 2012).

Dialectical Behavior Therapy (DBT) is currently the most extensively studied and used approach to treat BPD (Heard & Linehan, 2005; Lieb, Zanarini, Schmahl, Linehan, & Bohus, 2004; Linehan, 1993; Linehan, Cochran, & Kehrer, 2001; Zanarini, 2009). This type of cognitive-behavior therapy enhances adaptive behavior skills to cope with emotions, distress and interrelationship difficulties (Linehan, 1993). Dialectical Behavior Therapy has shown to be effective in randomized controlled trials (see Lynch, Trost, Salsman, & Linehan, 2007). The treatment has been shown in the past to be beneficial for anger, general mental health (Stoffers et al., 2012), suicidal and self-destructive behavior (Harned, Banawan, & Lynch, 2006; Linehan, Armstrong, Suarez, Allmond, & Heard, 1991; Linehan, Heard, & Armstong, 1993; Linehan et al., 1999; Stoffers et al., 2012) and, as a consequence, the number of hospitalizations (Harned et al., 2006; Linehan et al., 1991, 1993, 1999). Yet, according to recent (meta-)analyses, the effects of DBT on global symptoms as well as the effects on specific symptoms are moderate (Cohen's $d \approx 0.50$; Kliem, Kröger, & Kosfelder, 2010; Stoffers et al., 2012).

Other two relatively well-studied psychological treatments for BPD are the Mentalization-Based Treatment (MBT) and the Transference Focused Psychotherapy (TFP), both psychodynamic approaches (Zanarini, 2009). MBT derives from the attachment and cognitive theory and hypothesizes that early attachment difficulties have led to impairments in the capacity of BPD patients to mentalize, in other words, to be aware of and understand their own and others' mental states. The therapy focuses on increasing mentalizing capacities to achieve stability of affect and impulses (Bateman & Fonagy, 2010). MBT has been found to be superior to Treatment as Usual (TAU) in two trials conducted by the developers of MBT (Bateman & Fonagy, 1999, 2009), where suicidality, parasuicidality, interpersonal problems and depression were significantly reduced with very large effects (Stoffers et al., 2010). A recent RCT, conducted by an independent team, found no evidence for superiority of MBT above a less intensive control treatment, supportive group therapy offered once every two weeks (Jørgensen et al., 2012). TFP aims to address the extreme, rigid and split off BPD internal representations of the self and others by focusing the attention of the treatment on analyzing and reframing the transference brought by the patient to the therapeutic relationship (Yeomans & Delaney, 2008). TFP has been found in a RCT superior to TAU (community treatment by experts) on overall BPD severity and attrition (Doering et al., 2010), but TFP did not lead to a complete improvement of the impulsivity features of BPD (Clarkin et al., 2007) nor general psychopathology and global functioning (Stoffers et al., 2012).

The aim to find a treatment that leads to strong positive changes in all facets of the disorder and related elements, like quality of life and social functioning, motivates the interest in finding alternatives for the treatment of BPD. One of the emerging alternatives is schema therapy (ST; Young & Klosko, 1993; Young, Klosko, & Weishaar, 2003). This treatment has evolved greatly over the last 20 years (Kellog & Young, 2006) and has lately received a lot of attention from the scientific community, particularly in The Netherlands, Scandinavia, and United Kingdom (Nordahl & Nysæter, 2005). Its increasing popularity is mainly due to the results of a RCT, where ST was found to have greater positive effects on a broader range of symptoms compared to TFP (Giesen-Bloo et al., 2006).

Theoretical principles of ST have recently been described with respect to BPD (Nysaeter & Nordahl, 2008). However, review publications on both effectiveness and empirical evidence for the theoretical background of the therapy are lacking. At this point, it is important to evaluate the theoretical and empirical basis of ST before it can be considered as a well-established approach. Therefore, the current paper will address two questions. First, to what extent can an empirical foundation be found for the theoretical background of the schema model? Second, how effective and feasible is ST for the treatment of