KŁAK, Igor, SZEROCKI, Jan, WINKOWSKA, Alicja, GRUDINA, Alina, BARTNIK, Katarzyna, CHWALEBA, Katarzyna, MILEWSKA-PLIS, Katarzyna, MAZUR, Ksenia, HERIAN, Mariola and KARALUS, Monika. Schema Therapy – a powerful tool in management of Borderline Personality Disorder. Quality in Sport. 2025;44:62846. eISSN 2450-3118.
https://doi.org/10.12775/QS.2025.44.62846
https://apcz.umk.pl/QS/article/view/62846

The journal has been awarded 20 points in the parametric evaluation by the Ministry of Higher Education and Science of Poland. This is according to the Annex to the announcement of the Minister of Higher Education and Science dated 05.01.2024, No. 32553. The journal has a Unique Identifier: 201398. Scientific disciplines assigned: Economics and Finance (Field of Social Sciences); Management and Quality Sciences (Field of Social Sciences).
Punkty Ministerialne z 2019 - aktualny rok 20 punktów. Załącznik do komunikatu Ministra Szkolnictwa Wyższego i Nauki z dnia 05.01.2024 l.p. 32553. Posiada Unikatowy Identyfikator Czasopisma: 201398. Przypisane dyscypliny naukowe: Ekonomia i finanse (Dziedzina nauk społecznych); Nauki o zarządzaniu i jakości (Dziedzina nauk społecznych).
The authors declare that there is no conflict of interest regarding the publication of this paper.
Received: 23.06.2025. Revised: 21.07.2025. Accepted: 21.07.2025. Published: 06.08.2025.

Schema Therapy – a powerful tool in management of Borderline Personality Disorder

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Abstract

Borderline Personality Disorder (BPD) is a clinically significant psychiatric condition characterized by fear of abandonment, emotional and interpersonal instability, identity disturbance, impulsivity, and self-harming or suicidal behaviors. Its etiology involves a complex interplay between genetic predispositions and early developmental trauma, particularly attachment disruptions. BPD is associated with a high risk of suicide and self-injurious behavior. Currently, there is no pharmacological treatment that directly targets the core pathology of BPD; medications are used symptomatically. The gold standard in management is long-term psychotherapy. Schema Therapy (ST) and Dialectical Behavior Therapy (DBT) have demonstrated superior efficacy compared to treatment-as-usual, with ST showing the highest effectiveness in reducing suicidal behaviors. ST is an integrative therapeutic approach that focuses on unmet emotional needs underlying the formation of Early Maladaptive Schemas (EMSs). These schemas elicit maladaptive coping styles, which

in turn give rise to transient schema modes. From the ST perspective, BPD emerges from the interaction between innate vulnerability and early, often traumatic, familial experiences. A central feature is the Abandonment/Instability schema. Rapid shifts between coping styles and schema modes are characteristic of BPD, frequently involving activation of the Abandoned Child, Punitive Parent, and Detached Protector modes. Treatment within ST emphasizes limited reparenting, emotion-focused techniques, and mode modification, with the primary goal of fostering the Healthy Adult mode. Schema Therapy is increasingly recognized as one of the most effective psychotherapeutic approaches for treating BPD.

Key words: Borderline Personality Disorder, Schema Therapy

Introduction

Borderline Personality Disorder (BPD) is an uncommon but clinically significant mental health condition, initially described by Stern [1] and Knight [2] as existing on a spectrum between schizophrenia and neurosis. It was later more clearly conceptualized by Otto Kernberg [3] and John Gunderson [4] , who emphasized its psychoanalytic underpinnings. They proposed that BPD stems from primitive defense mechanisms such as splitting and projective identification, leading to impaired object relations and rapid shifts in perception from idealization to devaluation (i.e., viewing others as "all good" or "all bad"). The disorder was formally introduced into psychiatric nosology in the DSM-III [5] , largely influenced by the work of Spitzer [6] , which built upon Kernberg's theory of borderline personality organization and Gunderson's clinical research. Since its inclusion in DSM-III, the diagnostic criteria have remained largely stable through to DSM-5 [7] , the current edition. Each of present clasifications DSM-5, ICD-10 [8] and ICD-11 [9] emphasize core features of BPD such as fear of

abandonment, unstable relationships, identity disturbance, impulsivity, self-harming behavior, emotional instability, and persistent feelings of emptiness.

Etiology involves a combination of genetic vulnerability and early developmental trauma, particularly attachment disruptions or abuse during childhood [10] . Prevalence in the general population is estimated at 0.2% to 2.7% [11] , but it is significantly higher in clinical settings. Approximately 12% in outpatient and 22% in inpatient psychiatric populations [12] . BPD commonly co-occurs with major depressive disorder, bipolar disorder, generalized anxiety disorder, ADHD, eating disorders and substance use disorders [13,14] . Moreover, Borderline Personality Disorder is also strongly associated with an elevated risk of suicide and self-harm. In individuals with (BPD), the risk is particularly pronounced up to 10% of patients ultimately die by suicide [15] . The lifetime prevalence of suicide attempts in this population is estimated at 60–90% [16] , [17] , significantly exceeding rates observed in the general population. Additionally, approximately 65–80% of individuals with BPD engage in non-suicidal self-injury (NSSI) at some point in their lives [18] .

Currently, there is no pharmacological treatment that cures BPD [19] . Medications are used symptomatically to address comorbid conditions such as anxiety, depression, or impulsivity. The gold standard of treatment is long-term psychotherapy (minimum of 3 months) [20] . Although there is no strong evidence that one psychotherapeutic method is more effective than another [21] , Schema Therapy (ST) and Dialectical Behavior Therapy (DBT) have been shown to be statistically more effective than Treatment As Usual (TAU) in managing symptoms of Borderline Personality Disorder (BPD) [22] . The same study reported that ST achieved the highest SUCRA score among all psychotherapies in reducing suicidal behaviors. Schema Therapy is gaining popularity in Poland, and the aim of this paper is to summarize its core concepts in the treatment of BPD.

Diagnosis

There is growing concern in clinical psychiatry regarding the diagnostic accuracy of Borderline Personality Disorder (BPD) due to significant symptom overlap with other psychiatric conditions [13] . Many of its core diagnostic features such as fear of abandonment unstable interpersonal relationships identity disturbance impulsivity self-harming behavior affective instability and chronic feelings of emptiness are transdiagnostic and commonly

observed in a range of other disorder [13] . For instance Bipolar Disorder is frequently overdiagnosed in female patients who present with these symptoms whereas further clinical evaluation often reveals a diagnosis of BPD [23] . In contrast neurodevelopmental disorders such as Attention-Deficit Hyperactivity Disorder may initially be misclassified as BPD due to impulsivity and emotional dysregulation [24] . Cultural and gender biases also contribute to diagnostic confusion. For example symptoms of Antisocial Personality Disorder may be misinterpreted as BPD particularly in cases where contextual or cultural understanding of behavior is limited [25] . Misdiagnosis of BPD has serious implications both clinically and socially. Women labeled with BPD frequently encounter stigma and negative stereotypes which can hinder access to effective treatment and reinforce marginalization [26] , [27] , [28] . A key factor complicating the diagnosis is the lack of a unified nosological framework. Although DSM-5 and ICD-10 share the core features of BPD they emphasize different secondary criteria. ICD-10 includes the absence of stable goals and preferences including sexual preferences which are not explicitly addressed in DSM-5. Conversely DSM-5 includes transient stress-related paranoia or dissociative symptoms which are not part of ICD-10's definition. Moreover ICD-10 categorizes BPD as a subtype of Emotionally Unstable Personality Disorder whereas DSM-5 defines it as a distinct clinical entity [7,8] .

A more dimensional and nuanced approach to personality pathology is introduced in ICD-11 which is scheduled for implementation in Poland in 2028 [29] . Unlike the categorical structure of ICD-10 ICD-11 begins with the assessment of general criteria for personality disorder followed by an evaluation of severity categorized as mild moderate or severe. If the diagnostic threshold is not met but personality-related dysfunction is present the diagnosis of Personality Difficulty may be applied. Subsequently trait domains that contribute to personality dysfunction are identified. According to the ICD-10 to ICD-11 crosswalk developed by Bach et al. the presentation of BPD corresponds most closely with the trait domains of negative affectivity (tendency to experience a broad range of negative emotions with a frequency and intensity out of proportion to the situation), disinhibition (tendency to act rashly based on immediate external or internal stimuli without consideration of potential negative consequences) and dissociality (disregard for the rights and feelings of others, encompassing both self-centeredness and lack of empathy) [30] . ICD-11 also introduces the Borderline Pattern Qualifier which may be applied when an individual meets at least five of nine characteristic features of BPD corresponding to DSM-5 criteria. In practice a comprehensive ICD-11

diagnosis may read for example *Severe Personality Disorder with Borderline Pattern with Negative Affectivity, Disinhibition and Dissociality*. This updated framework highlights the complexity of BPD and underscores the importance of accurate and individualized assessment. Optimizing diagnostic precision is critical for guiding effective treatment planning and improving clinical outcomes.

History and Core Concepts of Schema Therapy

Schema Therapy (ST) is considered a third-wave cognitive-behavioral therapy, originally developed by Jeffrey E. Young. Initially trained in psychoanalysis, Young later shifted his focus to cognitive-behavioral therapy (CBT), becoming a direct collaborator of Aaron Beck, the founder of CBT. Through his clinical work, Young observed that standard CBT protocols were often insufficient in treating chronic and recurrent depression as well as personality disorders, particularly due to their complexity and entrenched patterns of dysfunction [31] . In response, he developed Schema Therapy by extending the duration of treatment and integrating elements from other therapeutic schools, including psychoanalytic theory, Gestalt therapy, and traditional CBT. The resulting integrative model aimed to personalize therapy, deepen the understanding of patients' emotional experiences, and offer structured yet flexible treatment strategies [31] . Over time, Schema Therapy demonstrated efficacy not only for personality disorders but also for a broader range of psychiatric conditions [32–34] .

Central to Schema Therapy is the concept of core emotional needs - fundamental psychological requirements that must be met for healthy emotional development. Young [35] initially identified five such needs:

1. Secure attachment to others (encompassing safety, stability, nurturance, and acceptance)
2. Autonomy, competence, and a sense of identity
3. Freedom to express valid needs and emotions
4. Spontaneity and play
5. Realistic limits and self-control

Subsequently, Arnoud Arntz et al. [36] expanded the model by proposing two additional core needs, based on empirical clinical research:

1. Fairness
2. Coherent identity

While these needs are important throughout life, they are especially critical during childhood, where they shape emotional, cognitive, and interpersonal development. When these core needs are unmet, individuals may develop Early Maladaptive Schemas (EMSs) which are pervasive, dysfunctional patterns composed of memories, emotions, and cognitions regarding the self and others. These schemas typically emerge in childhood or adolescence, become elaborated over time, and significantly distort how individuals interpret and respond to life experiences [35] .

Importantly, EMSs do not include behavior per se; rather, maladaptive behaviors are seen as reactions to the activation of schemas. These reactions are driven by a human tendency toward cognitive-emotional consistency, which may lead individuals to remain in harmful environments simply because they feel familiar. There are currently 21 recognized EMSs [36] , each representing the consequence of unmet core emotional needs.

1. Secure attachment: Emotional Deprivation, Mistrust/Abuse, Abandonment/Instability, Social Isolation, Defectiveness/Shame
2. Autonomy and identity: Dependence/Incompetence, Failure, Vulnerability to Harm or Illness, Enmeshment/Undeveloped Self
3. Emotional expression: Subjugation, Self-Sacrifice, Approval-Seeking
4. Spontaneity and play: Negativity/Pessimism, Emotional Inhibition, Unrelenting Standards, Punitiveness
5. Realistic limits: Entitlement/Grandiosity, Insufficient Self-Control/Self-Discipline
6. Self-coherence: Lack of a Coherent Identity, Lack of a Meaningful World
7. Fairness: Unfairness

Patients tend to respond to EMSs through maladaptive coping responses, which are automatic, internalized reactions to schema activation. These responses are shaped by individual temperament, genetic predispositions, and life experiences, especially trauma. Young [35] described three primary coping styles :

1. Surrender – Accepting the schema as true and behaving accordingly
2. Avoidance – Evading schema activation through mental or behavioral strategies
3. Overcompensation – Acting as though the opposite of the schema is true, often in exaggerated or rigid ways

The interaction of these coping responses with EMSs gives rise to schema modes, which are momentary states encompassing emotions, thoughts, and behaviors that occurs in reaction to activated EMS in a particular moment [36] . Unlike EMSs, which are trait-like and stable over time, schema modes are more state-like and include observable behavior. They are closely linked to symptomatic behavior and emotional dysregulation.

Schema modes are classified into four broad categories:

1. Child modes (e.g., Vulnerable Child, Angry Child)
2. Dysfunctional coping modes (e.g., Detached Protector, Compliant Surrender)
3. Dysfunctional parent modes (e.g., Punitive Parent, Demanding Parent)
4. Healthy modes, which include the Happy Child and the Healthy Adult, the latter being the central therapeutic target in Schema Therapy.

By identifying and restructuring EMSs and schema modes via limited reparenting, experiential imagery and socratic dialogue, restructuring of cognitive processes and breaking of behavioral patterns [31] Schema Therapy offers a comprehensive model for understanding and treating deeply ingrained patterns of dysfunction, particularly in individuals with complex and treatment-resistant psychopathology such as BPD.

Borderline Personality Disorder from Schema Therapy perspective

From the perspective of Schema Therapy, the development of BPD is understood to result from the interaction of three core etiological domains: genetic and temperamental predispositions, early childhood experiences within the family and broader environment, and the dynamic interplay between the child's temperament and the caregiving style [31] . In the developmental histories of many individuals with BPD, recurring patterns in the familial environment are frequently observed, including a lack of safety and stability, harshly punitive or rejecting behavior from caregivers, and experiences of subjugation. Although a history of sexual abuse may be present in some cases, it is not considered a necessary condition for the development of BPD. Rather, Young emphasizes the central role of significant mismatches

between the child's temperament and that of the parents or caregivers, which contributes to the formation of maladaptive schemas [31] .

A particularly salient Early Maladaptive Schema associated with BPD is the Abandonment or Relational Instability schema. This schema often leads to core beliefs that others, including loved ones, are fundamentally unreliable, emotionally inconsistent, or incapable of providing stable support, protection, or connection. Individuals with this schema may believe that others will inevitably leave them, either for someone better or due to uncontrollable events such as death. As outlined earlier, people respond to activated schemas through three primary maladaptive coping styles: surrender, avoidance, and overcompensation [35] .

In the context of BPD, these coping styles manifest in distinct relational behaviors. An individual using the avoidance style may withdraw from intimate relationships altogether out of fear of rejection or emotional pain. Through the surrender style, the person may repeatedly engage in relationships with emotionally unavailable or unpredictable partners, thereby reinforcing the schema. Conversely, in the overcompensation style, the individual may display clinging or controlling behaviors, demanding excessive attention and reacting with hostility to even minor separations or perceived threats of abandonment. This coping pattern may also involve emotional outbursts or attempts to dominate the partner in an effort to prevent anticipated rejection [35] .

A hallmark of BPD, as seen through the Schema Therapy framework, is the rapid and unstable cycling between these coping responses. This internal conflict is reflected in frequent shifts between several maladaptive schema modes. The most commonly activated modes in BPD include the Abandoned and Abused Child, characterized by intense feelings of vulnerability and fear of abandonment; the Angry and Impulsive Child, marked by uncontrolled rage and impulsivity; the Detached Protector, which serves to numb emotional pain through withdrawal or dissociation; and the Punitive Parent, which internalizes self-directed criticism and harsh judgment. The constant fluctuation between these modes contributes to the emotional instability and interpersonal dysfunction that define the clinical picture of BPD [31] .

Treatment

Treatment of Borderline Personality Disorder within the Schema Therapy framework involves four primary mechanisms: limited reparenting, emotion-focused work, cognitive restructuring

and education, and behavioral pattern breaking. These mechanisms are applied across three sequential phases of therapy: the initial phase of bonding and emotional regulation, followed by schema mode change, and culminating in the development of autonomy. In the first phase, the therapeutic focus is on establishing a secure, consistent, and emotionally validating relationship with the patient as a corrective experience in contrast to the dysfunctional and often harmful relational patterns experienced in early life. This therapeutic relationship is characterized by openness, empathy, and support, encouraging the patient to express a full range of emotions, needs, and desires, including anger, within the context of stability, safety, and clearly defined boundaries. In the early stages of treatment, emotional attunement and empathic validation are often more critical than problem-solving interventions [35] , as patients with BPD typically enter therapy with a deeply rooted belief that others are unreliable and prone to abandonment. The therapeutic goal is to provide a reparative emotional experience by meeting core emotional needs within the context of a safe and supportive therapeutic alliance, a process known as limited reparenting [35] .

Initially, the therapist works with current life situations to demonstrate to the patient that emotional expression is acceptable and safe. When appropriate, therapists may engage in limited self-disclosure to model openness. Once a basic level of trust is established, therapy gradually shifts focus to earlier developmental experiences, particularly those in adolescence and childhood. A key component of this phase is to maintain the patient in the vulnerable state associated with the Abandoned or Abused Child mode, as it is through this vulnerability that core unmet emotional needs can be directly accessed and addressed. Meeting these needs fosters a strong therapeutic bond, which is crucial given the emotionally intense and often prolonged course of treatment. Experiential techniques, such as imagery rescripting, are particularly valuable in this phase and are used throughout the therapy process to deepen emotional insight and restructure early maladaptive schemas [31] .

Maintaining the patient in the appropriate schema mode is essential, as the activation of other modes, such as the Angry and Impulsive Child, may lead to defensive reactions that sabotage therapeutic progress. One therapeutic task is to help the patient express anger constructively, without internalizing it in self-destructive ways or externalizing it in ways that damage the therapeutic relationship. By the end of the first phase, the patient should be able to access their unmet emotional needs and longings and begin to identify triggers for self-harming

behaviors such as cutting, substance abuse, impulsive sexual activity, and suicidal ideation or attempts. Psychoeducation about the schema mode model and guidance on recognizing mode shifts in daily life is also introduced at this stage to enhance the patient's self-awareness and emotional regulation [31] .

The second phase of treatment focuses on modifying maladaptive schema modes. During this phase, the therapist continues to maintain a secure connection with the patient's Abandoned or Abused Child mode while helping the patient explore and understand the full range of their schema modes, including their intensity and interaction. In patients with BPD, the most commonly activated modes include the Detached Protector, the Punitive Parent, and the Angry and Impulsive Child. The Detached Protector emerges in response to early trauma and serves as a defense mechanism to block emotional pain. Although it may have been adaptive during periods of acute distress, its continued activation in adulthood prevents emotional engagement and obstructs access to vulnerable schema modes. The first therapeutic task in addressing the Detached Protector is to help the patient recognize its presence, assess its historical utility, and evaluate its current costs. Imagery, dialogue, writing exercises, and cognitive techniques are employed to illustrate the functional and emotional limitations of the mode and to challenge dichotomous thinking [31] .

When working with the Punitive Parent mode, the primary goal is to identify and externalize its critical internal voice. Naming and labeling this voice helps reduce its emotional power, providing the patient with psychological distance and insight. This mode often embodies the internalized attitudes of critical or neglectful caregivers, and understanding the unmet emotional needs embedded in the punitive voice is an essential step in schema modification. Therapeutic dialogues, in which the therapist interacts with the patient as if speaking through the punitive mode, are used to model assertive responses and empower the patient to defend their emotional needs and rights [35] .

The Angry and Impulsive Child mode is often a manifestation of rage against early experiences of neglect, rejection, or abuse. This mode may intensify as the patient relinquishes more controlling or avoidant modes, such as the Detached Protector. Patients with BPD often long for nurturing and affirmation, yet this cannot be delivered in a parental manner, as the therapeutic process is based on limited reparenting rather than literal parenting. Anger is frequently stigmatized in the histories of these individuals, and therefore, it is

essential to normalize anger as a valid emotional response while also teaching patients how to manage and express it adaptively. During sessions involving anger outbursts, therapists should explore the origins of the emotion, empathize with the underlying vulnerability, and help the patient shift back into the Abandoned or Abused Child mode. Interventions such as reality testing, identifying activated schemas, and rehearsing alternative behavioral responses support emotional regulation and foster behavioral change [31] .

In the third and final phase of treatment, the focus shifts to behavioral pattern breaking and the development of autonomy. Patients begin to apply the skills and insights gained in therapy to real-life situations and interpersonal relationships. This includes practicing assertiveness, developing social skills, and anticipating and managing potential interpersonal challenges. Techniques such as role-playing and behavioral rehearsal are used to support this process. Achieving autonomy is often a gradual and demanding task, requiring sustained therapeutic support. However, through consistent application of schema-focused strategies, patients with BPD can develop a stronger Healthy Adult mode, improve emotional stability, and form more secure and satisfying relationships [31] .

Conclusion

Schema Therapy represents one of the most effective approaches to the treatment of Borderline Personality Disorder due to its integrative structure and individualized, patient-centered framework. While the method has its limitations, we hope that the growing number of Schema Therapy training programs and clinical centers in Poland will contribute to an increase in empirical research on its efficacy. Continued studies are essential to refine therapeutic protocols, improve outcomes, and establish evidence-based guidelines for managing BPD, particularly in cases complicated by psychiatric comorbidities.

Disclosure:

Author Contributions

Conceptualization, Igor Kłak, and Jan Szerocki; methodology, Alicja Winkowska; software, Ksenia Mazur; check, Alina Grudina, Katarzyna Chwaleba and Katarzyna Milewska-Pils; formal analysis, Igor Kłak; investigation, Alicja Winkowska; resources, Katarzyna Bartnik; data curation, Maiola Herian; writing - rough preparation, Jan Szerocki; writing - review and editing, Igor Kłak; visualization, Monika Karalus; supervision, Igor Kłak; project administration, Igor Kłak.

All authors have read and agreed with the published version of the manuscript.

Funding Statement: The study did not receive special funding.

Institutional Review Board Statement: Not applicable.

Informed Consent Statement: Not applicable.

Data Availability Statement: Not applicable.

Acknowledgments: The authors acknowledge the use of OpenAI's ChatGPT for assistance with the English translation and stylistic editing of the manuscript. The tool was employed solely for linguistic purposes and did not contribute to the scientific content or interpretation of the work.

Conflict of Interest: All authors declare no conflict of interest.

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