



UvA-DARE (Digital Academic Repository)

Schema Therapy for adults with autism spectrum disorder and comorbid personality disorder: A case example

Vuijk, R.; van Genderen, H.; Geurts, H.M.; Arntz, A.

Publication date

2022

Document Version

Final published version

Published in

Adults with autism spectrum disorder

[Link to publication](#)

Citation for published version (APA):

Vuijk, R., van Genderen, H., Geurts, H. M., & Arntz, A. (2022). Schema Therapy for adults with autism spectrum disorder and comorbid personality disorder: A case example. In R. Vuijk (Ed.), *Adults with autism spectrum disorder: Diagnostic assesment, personality (pathology), and psychotherapy* (pp. 115-126)

General rights

It is not permitted to download or to forward/distribute the text or part of it without the consent of the author(s) and/or copyright holder(s), other than for strictly personal, individual use, unless the work is under an open content license (like Creative Commons).

Disclaimer/Complaints regulations

If you believe that digital publication of certain material infringes any of your rights or (privacy) interests, please let the Library know, stating your reasons. In case of a legitimate complaint, the Library will make the material inaccessible and/or remove it from the website. Please Ask the Library: <https://uba.uva.nl/en/contact>, or a letter to: Library of the University of Amsterdam, Secretariat, Singel 425, 1012 WP Amsterdam, The Netherlands. You will be contacted as soon as possible.

6

Schema Therapy for adults with autism spectrum disorder and comorbid personality disorder: A case example

Richard Vuijk, Hannie van Genderen, Hilde M. Geurts, Arnoud Arntz

- 6.1 Introduction to Schema Therapy - 117
- 6.2 Autism spectrum disorder: Personality weaknesses and strengths - 118
- 6.3 ASD and Schema Therapy - 119
- 6.4 Schema Therapy for people with ASD: Clinical considerations - 120
- 6.5 Case study: Christian - 122
 - 6.5.1 Demographic information - 122
 - Living situation*
 - History*
 - 6.5.2 Presenting problems - 122
 - 6.5.3 Assessment and diagnosis - 123
 - 6.5.4 Individualized treatment plan - 123
 - Goals*
 - Schema Therapy*
 - 6.5.5 Experiential interventions - 123
 - Imagery rescripting*
 - Chairwork dialogue*
 - 6.5.6 Evaluation of treatment - 126
- 6.6 Conclusion - 126

This chapter has been published as:

Vuijk, R., Van Genderen, H., Geurts, H.M., & Arntz, A. (2022). Schema Therapy. In D. Spain, F.M. Musich, & S.W. White (Eds.), *Psychological Therapies for Adults with Autism* (pp. 165-175). Oxford University Press.

Abstract

This chapter outlines Schema Therapy (ST) as a treatment possibility for adults with autism spectrum disorder (ASD) and comorbid personality disorder (PD). ST is introduced, followed by a summary of empirical findings about personality characteristics in people with ASD including both weaknesses (i.e., pathology) and strengths. A summary is provided of the empirical studies examining ST concepts and treatment programs for adults with ASD (and comorbid PD). The chapter concludes with a case study exemplifying the ST approach.

Author contributions

All authors contributed to the conception and design. Hannie van Genderen drafted the introduction. Richard Vuijk drafted the manuscript with critical input from the other authors. All authors read and approved the final manuscript.

6.1 Introduction to Schema Therapy

Schema Therapy (ST) is an innovative, integrative therapeutic approach originally developed by Jeffrey Young as an extension of traditional cognitive behavioral treatments (Young et al. 2003). The schema approach draws from cognitive behavioral therapy (CBT), attachment theory, psychodynamic concepts, and emotion-focused therapies. ST is particularly well-suited and effective for people with chronic mental disorders, including personality disorders (PDs), eating disorders, and chronic depression (Bamelis et al. 2014; Renner et al. 2013; Sempérteguia et al. 2013; Simpson et al. 2010).

A central tenet of ST, drawn from CBT, is that everyone develops schemas during childhood. A schema is an organized knowledge structure that develops in early life and manifests in certain behaviors, feelings, and thoughts. Dysfunctional schemas (such as social alienation, social undesirability, failure, hypercriticalness, subjugation) develop when some core emotional needs (safety, acceptance, nurturance, autonomy, self-appreciation, self-expression, and realistic limits) are not met during formative years. This may be due to shortcomings in the child's environment, or in combination with traumatic events (such as emotional, physical, or sexual abuse, or being bullied) in interaction with the child's temperament. A coping response in combination with a schema results in a so-called schema mode, which describes the momentary emotional-cognitive-behavioral state of the person. A schema mode (such as vulnerable child, happy child, compliant surrender, detached self-soother, demanding parent) is a set of schemas and processes, which, in certain situations, determine the thoughts, feelings, and actions of the person.

ST focuses on changing dysfunctional schemas and maladaptive modes into more flexible and less extreme schemas/modes, and developing adequate coping strategies so that clients develop a more positive image of themselves and others, as well as a more nuanced view of the world around them. First, the therapist and client create a case conceptualization based upon the schemas and modes. Next, in the treatment phase, therapists make use of experiential, cognitive, and behavioral techniques, influencing the client through three channels: feeling (experiential), thinking (cognitive), and doing (behavioral). The experiential techniques (including imagery rescripting, chair work dialogue, historical roleplay) seem to be the most crucial mechanisms of change, as they appear to change the schemas and modes on an emotional, as well as cognitive level. The application of ST techniques can only be successful once a certain level of trust and attachment to the therapist is formed. The therapeutic relationship can be described as limited reparenting, whereby the therapist goes into this relationship as if they are a parent figure for the client.

6.2 Autism spectrum disorder: Personality weaknesses and strengths

An increasing number of studies have examined autism spectrum disorder (ASD) and comorbid personality pathology. A literature review by Vuijk et al. (2018; see Chapter 3) showed strong indications for personality pathology in adults with ASD, such that ASD appeared to be significantly associated with several temperament and character dimensions, and with major PDs. Some adults with ASD, for example, were found to have an introverted, rigid, and passive-dependent temperament and a risk for deficits in character development with low self-directedness and cooperativeness. The majority of adults with ASD do not have a co-occurring PD, but prevalence of PD appears to be higher than in neurotypical adults. The prevalence of meeting criteria for a PD ranges from 48% to 62% among adults with ASD drawn from clinical samples (Hofvander et al. 2009; Lugnegård et al. 2012). Results of a meta-analysis (Vuijk et al. 2018; see Chapter 3) indicated that the most common PDs were paranoid (24%), schizoid (24%), schizotypal (14%), avoidant (23%), and obsessive-compulsive (32%). To summarize, there is a strong association between ASD and dysfunctional personality traits, as well as between ASD and PD, specifically cluster A (paranoid, schizoid, schizotypal) and cluster C (avoidant, dependent, obsessive-compulsive) PDs.

Both ASD and personality disorder (PD) are associated with a long-term pattern of difficulties in interpersonal functioning. ASD is characterized by persistent problems in social communication and social interaction; in other words, a persistent social disability or a neurodevelopmental condition with a focus on problems in the social domain. PD is not characterized by a persistent social disability, but by interpersonal difficulties, based on a combination of temperament difficulties and early problematic relationships with others, attachment pathology and/or stressful situations or events. Each of the DSM-5 PDs (American Psychiatric Association 2013) describes particular types of interpersonal difficulties. For example, when having an avoidant PD, contact is disturbed by feelings of inadequacy and hypersensitivity to being negatively evaluated. In our case study we will meet Christian, diagnosed with ASD (in his childhood) and in adult life with comorbid avoidant PD traits: for him, ASD means a challenge and difficulty in interpreting verbal and nonverbal communication, reading other people's emotions, and expressing his own emotions. In his childhood his parents and his peers did not always know how to deal with his ASD. In childhood, negative reactions of others were a real burden and a serious cause of stress for him: he developed low self-esteem and a pattern of fear of being negatively evaluated. The combination of the negative reactions and his thoughts and feelings shaped his personality in an avoidant way.

Importantly, research shows that ASD is also associated with positive personality attributes. In a study examining character strengths in adults with ASD, intellectual open-mindedness (i.e., thinking things through, examining aspects from all sides), authenticity, love of learning, creativity, and fairness were found to be the most frequent signature strengths (Kirchner et al. 2016).

6.3 ASD and Schema Therapy

People with ASD may have a vulnerability to maladaptive schema development, partly because of their different ways of processing information about others, the self, and nonsocial information, often resulting in social difficulties as well as difficulties with self-management (Gaus 2019). For example, children with ASD might be at risk of being misunderstood, excluded, and maltreated because of their ASD and/or the impact of symptoms. Such early experiences are well-known risk factors for deficits in character development and the development of PDs. Adults with ASD have scored significantly higher on all the early dysfunctional schemas, apart from self-sacrifice and approval/recognition seeking, compared to typically developing adults (Oshima et al. 2015). Early dysfunctional schemas have also appeared to account for poorer general mental health in nonclinical adults with autism spectrum traits (Oshima et al. 2014).

The increased recognition of personality pathology in adults with ASD implies the need for interventions for personality pathology in this population. To date, very few studies have examined the acceptability and effectiveness of psychosocial interventions for PD in adults with ASD. A naturalistic multiple case study ($N=8$, aged 20 to 35, four males, four females) indicated that individual ST is applicable as a treatment for adults with ASD and comorbid psychiatric conditions narratively showing positive changes in quality of life, symptoms of ASD, cognitive schemas, and schema modes (Oshima et al. 2018). However, a lack of specific details and limited documentation of methodology and statistical analysis renders this study difficult to interpret the positive changes. A specific ST program for adults with ASD and comorbid PDs has been developed and investigated by Vuijk and Arntz (2017; see Chapter 7). As far as we know, this is the first study investigating ST in adults with ASD and comorbid PD(s). Results of this study are promising, showing a significant decrease of dysfunctional core beliefs, PD traits, psychopathological symptoms, an increase of the functional schema mode of Happy Child, and an improvement in social responsiveness. These results are expected to be published in 2022 (see Chapter 8).

For several reasons, ST might be a useful therapy for adults with ASD and comorbid PD (see also Vuijk & Arntz 2017; Chapter 7). First, there is increasing empirical support for this therapy as a valuable treatment for PDs, as described in the beginning of this chapter. Second, the therapeutic relationship is active, consistent, supportive, and directive with regard to both content and process, which we consider helpful for people with ASD who are more often characterized by low self-directedness as compared to the general population. Third, ST is a structured and focused psychotherapy, suitable for people with ASD, who often seem to benefit from this way of working. Thus, the approach common in ST (i.e., step by step, focused on a theme, structured by explanation and psychoeducation, and goal-directed) is likely to be of use for people with ASD. A *Schema Therapy Modified for Autism Spectrum Conditions* (ST-MASC) was developed by Bulluss (2019). This model provides a framework and an extension of the regular ST elements in which autism-driven coping responses and autism-specific needs are incorporated and conceptualized. The model provides illustrative examples of how some people with ASD cope with their core autistic features living in a neurotypical world, using ST terms originally developed to describe how people can dysfunctionally cope with maladaptive schema activation: by surrendering, overcompensating, or avoiding. This can be understood in terms of eye contact, for example: (a) the coping response of surrendering for the tendency of limited eye contact is, for instance, staring at the floor or past people, (b) the coping response of overcompensating is focussing too much on making eye contact or staring at times, and (c) an avoidant coping response is avoiding situations involving face to face interaction, resulting in isolation. Autism-specific needs are, for instance, the freedom to focus on interests and a stable and reliable base for routine, predictability, and sameness.

6.4 Schema Therapy for people with ASD: Clinical considerations

When starting ST, there are some ‘dos and don’ts’ for a therapist treating PD in people with ASD:

- As a therapist, first take care to set clear expectations about the role of the therapist and the client, setting a realistic pace, using language effectively, validating the client’s experience, and providing constructive feedback (Gaus 2019).
- At the beginning of every ST session review psychoeducation of the ST concepts and the specific interventions in order to set clear expectations for clients with ASD. After an intervention, it is helpful to explain or discuss in detail what has been done and what it means for the client’s here-and-now situation.

- When cognitive restructuring dysfunctional core beliefs or schema modes, post-its (at the wall or in the chair when doing chair dialogues) can make beliefs or modes more visible and concrete in the here-and-now for clients with ASD.
- People with ASD often say they have never had the opportunity to explore difficult and challenging personal situations and getting constructive feedback on their thoughts and feelings. A man with ASD, avoidant PD, and traumatic memories caused by being bullied for 10 years in his childhood by other children was treated with ST: his reaction after imagery rescripting sessions was that the trauma had been solved because he had verbalized the trauma in therapy. For him, the trauma was easier to deal with in his daily life.
- For people with ASD, experiential interventions can be a challenge. For example, a woman with ASD and obsessive-compulsive PD could not imagine herself as a child. The therapist solved this as follows: he let her imagine a general family situation at a dinner table with a father, a mother, and a little child. After the intervention she discovered that in the imagery rescripting she had brought up her own family situation and she was the little child. Explaining, translating, and discussing afterwards can lead to expression of new functional beliefs about one’s self. Another example is a man with ASD and schizoid PD who said when starting imagery rescripting, ‘I do not feel, but I think. I have a clear and detailed picture how it used to be when I was a child: I do have no feelings, but only thoughts about it.’ The therapist can validate the client’s attempt to imagine: he did it in a cognitive way. He finally expressed new functional core beliefs (of the past) and could change his actual situation by improved cognitive mentalizing.

ST does not differ substantially for people with ASD compared to people with other mental disorders. ‘The psychotherapist needs to be fluent in “Aspergerese”; in other words, to recognize that autism is a different way of thinking – almost a different culture – and be able to translate the concepts and components of the therapy to someone with this different way of thinking’ (Gaus 2019, p. ix). Taking into account the ‘dos and don’ts’, the autism-specific needs and challenges, as well factoring in personality strengths, we believe ST can be a potential effective treatment for PD in people with ASD.

6.5 Case study: Christian

6.5.1 Demographic information

Living situation

Christian is a 52-year-old Dutch man. He lives alone, has no partner and no children. He worked for 23 years as a high school teacher in mathematics. Last year, he was dismissed: he was unable to deal with the major changes in the Dutch system for high school education. Currently, he works as a volunteer in a group home for elderly people one day a week, serving coffee and tea.

Christian is a member of a Dutch network for, and led by, adults with ASD, visiting its activities once a month. Further, he spends a lot of time home alone.

History

Christian is an only child. His father worked as a teacher in Latin language at high school. His mother was a nurse in a children's hospital. After high school Christian obtained his Master's degree in Mathematics at university.

During childhood, there was a lot of order and discipline at home. He experienced challenges in understanding others and playing with other children. His parents did not encourage him to join other children, so he seldom dared to participate: as a child, he felt afraid of his peers' negative reactions toward him, which he considered were due to him not knowing how to interact with them. He had a strong desire for interaction, but did not feel that he possessed the knowledge or skills to do this adeptly. In his childhood, he was a member of the Scout movement. When he participated in scouting activities, he was often a loner in the group and rarely involved in activities or plays. These experiences contributed to him feeling unlikable and unwanted, and he developed core beliefs relating to being different, not good enough, and bound to be alone. He developed a pattern of low self-esteem and avoidance of interpersonal contact, due to fear of disapproval and rejection.

6.5.2 Presenting problems

After being dismissed from his teaching post, Christian visited his general practitioner (family doctor), reporting depressed feelings and social anxiety. He was referred to a center specializing in diagnostic assessments and treatments for adults with ASD.

His key presenting difficulties were low self-esteem, a substantial need for order and interpersonal control, fear of negative evaluation, and a depressed mood. In addition, his ASD-specific challenges related to trying to understand what others meant: he often needed extra time to process what he hears, sees and feels when having contact with others.

In his manner, Christian presented as very kind. He regularly sought clarification regarding the actual meaning of remarks made by the therapist. He also asked for a clear and structured way of communicating and required time to provide what he felt was the right answer.

6.5.3 Assessment and diagnosis

Mental disorders were assessed at intake in a structured, organized, ASD-friendly way. After the assessment, his ASD was confirmed and Christian was additionally diagnosed with depressive disorder, social anxiety disorder, and avoidant PD traits. Pharmacological treatment, CBT, and ST were indicated.

6.5.4 Individualized treatment plan

Goals

First, depressive disorder and social anxiety disorder were treated with antidepressants and CBT focusing on scheduling enjoyable activities, physical exercise, relaxation skills, *in vivo* exposure and cognitive interventions. After a period of four months of treatment, ST was introduced to enhance Christian's ability to challenge dysfunctional core beliefs (schemas), coping styles, and schema modes: to increase functional coping styles and schema modes; and to help meet basic emotional needs.

Christian hoped to increase his competence and confidence in social situations, thereby feeling less anxiety and stress in these situations. He wanted to express new beliefs about himself, such as 'I am capable and competent' and 'I am good enough to be loved by others.' He also wanted emotional memories to feel less intense.

Schema Therapy

ST for Christian consisted of four phases: (a) 5 sessions exploring current and past functioning, psychological symptoms, dysfunctional core beliefs, and schema modes; (b) 15 weekly sessions of cognitive behavioral interventions; (c) 15 weekly sessions of experiential interventions; and (d) 10 monthly follow-up booster sessions.

6.5.5 Experiential interventions

Imagery rescripting and chairwork dialogues are powerful experiential techniques. Imagery rescripting uses the power of imagination and visualization to identify and change meaningful and traumatic orders in the past, resulting in transformation in the present (Wijngaart & Hayes 2016). Chairwork dialogues give a chair to the schema modes in the individual so that they can enact or re-enact scenes from the past, the present, or the future. To make these interventions more accessible for people with ASD, like Christian, the therapist takes into account the 'dos and don'ts' and the autism-specific needs and challenges mentioned in the fourth paragraph of this chapter. Here, we exemplify two experiential interventions by outlining

one of Christian's imagery rescripting sessions and chairwork dialogue sessions, helping him to bring about actual behavioral change and less intense emotions and memories. Christian described a recent situation in which he felt completely ignored by his colleague volunteers at the elderly home. At team meetings, he never felt able to say what he wanted to say, at the right time, as conversations moved on too quickly for him.

Imagery rescripting

Therapist (T): Christian, can you close your eyes and imagine the meeting from last week?

Christian (C): Yes, I am sitting in the meeting room, we are having a meeting with all 10 of the volunteers. Everyone is talking and mentioning things they want to say.

Everyone except me.

T: And what do you feel?

C: I feel frustrated.

T: Stay with that frustration for a moment. Can you feel it right now?

C: Yes, I feel it in my shoulders.

T: I want you to concentrate on that feeling. The situation with your colleagues.

Let it go. Go back to your childhood and see if a situation comes in mind in which you are also frustrated as a little child.

(Christian is thinking)

T: And do you have an image?

C: I am at scouting, and again, I am standing on the sidelines, I am not participating in building a tent and nobody asks me to join in. Even the leaders do not pay attention to me. I want to join, but I do not know how.

T: Is it okay, if I enter the image and talk to the leaders to support you?

C: Yes, that's okay.

T: *[To the leaders]* I would like you to know that little Christian is standing all alone and he wants to join. Can you please involve him in building the tent?

[To Christian] Is this okay for you, Christian?

C: Well, I am not convinced the leaders will listen to you.

T: Then, I will repeat it again and in a louder voice. *[Therapist repeats the message to the leaders with a louder voice.]*

C: Ah, that feels better. I can see that one of the leaders is coming up to me and asks me to join building the tent.

T: Okay, Christian, take a minute to enjoy the event. When you are okay with it, you may open your eyes and return to the therapy room. How do you feel?

C: This was for me the first time that someone [the therapist who came in the imagery exercise] was giving me support. It feels very good.

T: How can this exercise help you when being together with your colleagues?

C: *[Christian is thinking]* Well I think, I have to speak the manager before the meeting and ask her to give me some time to say something during the meeting.

T: That sounds good.

C: Yes, but I am not sure how I can ask her, how I have to do this.

T: Let us give it a try: we can practice this in a role play.

Chairwork dialogue

Christian was now confronted with two scenarios: "Do I still say nothing at team meetings or do I say what I want to say?" He felt very nervous thinking about this dilemma, having a voice in his mind telling him he would not succeed. The therapist invited him to a three-chair dialogue to give voice to what he was currently feeling and experiencing. In one chair he gave voice to his vulnerable child mode ("I feel ashamed of myself when starting conversation in a group"), in the second chair he gave voice to his demanding parent mode ("You will not succeed"), and in the third chair he gave voice to his healthy adult mode ("I know you find this scary, because you are not used to saying what you want to say at team meetings, but I know you will succeed. It is ok if you don't speak in perfect sentences. It is much more important that you speak up than that you strive for perfection, because then you are much more likely to say nothing").

The therapist guided him through the dialogue by asking him to take place vice-versa in the chairs, especially repeating and strengthening the functional words and thoughts that came up in Christian's mind. Christian switched several times from chairs, having a dialogue between his shame and social anxiety (vulnerable child mode), his highest standards and self-criticism (demanding parent mode), and his growing assertiveness and self-confidence (healthy adult mode), in the end resulting in less tense feelings and more realistic and confident thoughts about himself regarding the team meetings.

6.5.6 Evaluation of treatment

At follow-up Christian reported that he found ST a long and intensive treatment. During the therapy, he often wondered if all the interventions and the talking could glean a positive outcome. ST was confronting, yet in the end, he realized that it brought him new functional core beliefs about himself (such as “I am different, but I am good enough the way I am”; “I am confident enough in saying what I want to say”), better self-esteem, less anxious feelings and thoughts, and more skills to manage social interaction.

6.6 Conclusion

We believe ST might be a potential treatment for PD in people with ASD, when also taking into account the autism-specific needs and challenges and making use of the personality strengths. Randomized effectiveness studies are needed. Promising results of a first study examining ST in people with ASD and comorbid PD are expected in the near future (see Chapters 7 and 8).