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The Subjective Experience of the Punitive Parent Mode in Individuals With Borderline Personality Disorder Following Schema Therapy: A Qualitative Study

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ABSTRACT

Borderline personality disorder (BPD) is often characterized by self-critical and punitive thoughts, emotions, beliefs and behaviours, conceptualized in schema therapy (ST) as the punitive parent mode (PPM). This mode involves internalized punitive messages from childhood from the behaviour and reactions of significant others, leading to self-hatred, guilt and self-denial. Although patients with BPD frequently report auditory verbal hallucinations (AVHs) as manifestations of the PPM, this phenomenon is often overlooked in ST studies. We conducted semistructured interviews with 16 (ex)patients (63% female) from two Dutch mental health institutions to explore their experiences with the PPM before, during and after ST. An independent, double-coded systematic content analysis was performed. Approximately half of the participants reported AVHs linked to the PPM before therapy. The patients characterized the PPM by pervasive self-critical messages, contributing to intense emotional and physical distress and maladaptive coping strategies. Participants reported that ST techniques, including group therapy, imagery rescripting (ImRs) and the empty chair technique (ECT), effectively reduced the power and credibility of the PPM, including AVHs. The self-reported improvements included more adaptive coping mechanisms, increased social support and a general experience of reduced PPM. This study highlights the prevalence of the PPM as AVHs in individuals with BPD and demonstrates the efficacy of ST in reducing the impact of PPM, including in cases involving AVHs. Clinical implications include the need for relapse prevention plans and further exploration into how ST's effects can be enhanced. Future research should explore the broader spectrum of psychotic experiences in BPD and consider integrating PPM-related AVHs into the assessment and treatment of BPD.

1 | Introduction

Borderline personality disorder (BPD) is characterized by profound instability in emotional responses, self-identity, interpersonal relationships and dissociative experiences (American Psychiatric Association [APA] 2022). Research suggests that problematic parenting behaviours during childhood significantly increase the risk of developing personality disorders, including BPD (Johnson et al. 2006). Individuals with BPD often exhibit self-restrictive, critical and punitive thoughts; emotions; beliefs; and behaviours towards themselves and others (Nysæter and Nordahl 2008), which are thought to stem from internalized self-critical beliefs formed in response to early negative caregiving experiences alongside abuse and adverse experiences

Summary

- It is crucial to recognize that the punitive parent mode can occur as auditory verbal hallucinations, which has important consequences for providing comprehensive treatment to individuals with borderline personality disorder.
- The findings underscore the transformative potential of schema therapy in alleviating distressing symptoms associated with the punitive parent mode, such as auditory verbal hallucinations, because participants reported reduced intensity, frequency and credibility after schema therapy.
- Key techniques such as 'talking back' from the empty chair technique, strengthening the healthy adult mode, nurturing the inner child and setting aside positive experiences were instrumental in achieving these improvements.
- Additionally, patients learned to accept the punitive parent mode as part of their experience and developed strategies for managing it.

outside the immediate family (Arntz and Weertman 1999). Consequently, a punitive upbringing alongside adverse early life experiences may foster maladaptive thoughts and behaviours that are central to BPD.

Schema therapy (ST) is an evidence-based therapeutic approach for treating patients with BPD. It integrates cognitive-behavioural techniques with experiential techniques and developmental theories, including attachment and psychodynamic concepts. Central to ST are the concepts of early maladaptive schemas (EMSs) and schema modes. EMSs are pervasive, deep-rooted patterns of beliefs and emotions about oneself, others and the world. According to ST, these schemas develop in response to unmet core needs and early traumatic experiences. When EMSs are activated, individuals deal with this activation with a coping strategy, resulting in so-called schema modes, which are moment-to-moment emotional, cognitive and behavioural states (Young, Klosko, and Weishaar 2006). In BPD, the punitive parent mode (PPM) is particularly prominent, embodying internalized punitive messages (Arntz and van Genderen 2020; Lobbestael, Van Vreeswijk, and Arntz 2008). The PPM is the result of giving in (surrender coping) to the activation of the Punitiveness EMS. This mode is associated with problematic actions and feelings in BPD, such as self-criticism, self-injury and other self-destructive behaviours, anger towards the self, low self-esteem and self-hatred, guilt and shame (Young, Klosko, and Weishaar 2006).

The primary goal of ST is to help patients meet their psychological needs by reducing maladaptive schema modes and strengthening adaptive ones. This helps foster a healthier self-concept, self-regulation and improved interpersonal functioning. Two experiential techniques central to this process are the empty chair technique (ECT) and imagery rescripting (ImRs). In the ECT, patients address an empty chair as if it were occupied by a significant person or a part of themselves, such as the PPM (Kellogg 2012; Paivio and Greenberg 1995). Initially, the therapist challenges the PPM, and later, the patient learns to take on this role, fostering the healthy adult mode (Arntz and van Genderen 2020). ImRs, on the other hand, guides patients to re-evaluate distressing memories, including those that contributed to the development of the PPM. Patients learn to alter the course of events in their imagination, changing the narrative to introduce new and more positive outcomes in which their needs are met. This process weakens the EMSs by introducing corrective emotional experiences and information. By reprocessing and re-attributing traumatic experiences, patients reduce the emotional intensity of these memories and develop healthier schema modes (Arntz 2011; Arntz and Weertman 1999; Hackmann 2011). Together, these techniques contribute to transforming internal experiences, help to reduce the dominance of the maladaptive PPM and foster a more balanced, adaptive self (Young, Klosko, and Weishaar 2006).

Although previous studies have not explicitly focused on investigating the PPM, several qualitative studies with broader aims have explored individuals' experiences in addressing the PPM in ST (Josek et al. 2023; de Klerk et al. 2017; Schaich et al. 2020; Tan et al. 2018; van Maarschalkerweerd et al. 2021). However, no study so far has explored patients' experiences with the PPM before, during and after ST in depth. For example, de Klerk et al. (2017) observed that individuals with BPD sometimes struggle to connect past experiences with present ones during ImRs sessions, hindering the therapy's generalization and effectiveness. However, Tan et al. (2018) found that ST helped patients gain control over their internalized PPM, enabling them to distance themselves from their self-demands without self-blame. Schaich et al. (2020) reported that following ImRs, individuals experienced improvements in self-perception, acceptance, respect, relief, coping abilities and physical well-being, due to reduced self-blame and self-criticism. Josek et al. (2023) and van Maarschalkerweerd et al. (2021) found that while participants initially struggled to engage with ECT, the technique was ultimately beneficial in reducing the PPM's influence and promoting a transition to a healthier adult mode. Regardless of initial scepticism and emotional demands of ECT, participants found ECT beneficial. These studies underscore the complexities of transforming the PPM through ST.

Despite the important insights gained from these studies regarding the strengths and limitations of ST in addressing the PPM, ST textbooks and current research often overlook reports of BPD patients about experiencing the PPM as auditory verbal hallucinations (AVHs). AVHs are experiences of hearing voices without external stimuli (David 2004). While BPD patients often recognize these voices as originating from their minds (Barrera et al. 2021; Kingdon et al. 2010), there is a debate whether they should be diagnosed as 'true' (i.e., psychotic) hallucinations or as pseudohallucinations (Yee et al. 2005). BPD can thus be misdiagnosed as psychotic disorder (Beatson et al. 2019). Notably, approximately half of BPD patients report experiencing AVHs, which are phenomenologically indistinguishable from those in schizophrenia (Cavelti et al. 2021; Kingdon et al. 2010; Slotema et al. 2012). However, AVHs in BPD are typically more persistent, repetitive, derogatory and self-critical and have an earlier onset than those in schizophrenia (Hayward et al. 2022; Merrett, Rossell, and Castle 2016; Niemantsverdriet et al. 2017; Tseng and Georgiades 2024). Moreover, AVHs negatively impact

BPD progression, correlating with higher hospitalization and suicide risks (D'Agostino, Rossi Monti, and Starcevic 2019; Niemantsverdriet et al. 2017). These findings suggest that AVHs in BPD may be manifestations of the PPM.

AVHs can significantly affect individuals with BPD, and there is a possible connection between these experiences and the PPM in ST. This study aimed to investigate the experiences of (ex)patients who received ST for BPD, focusing on changes in the PPM and its possible manifestation as AVHs. The primary objective was to explore the subjective experiences of the PPM in BPD patients before, during and after ST, assessing the transformation of these experiences through therapy and examining the impact of ST techniques on mitigating the PPM and possible related AVHs.

2 | Method

2.1 | Study Design

To gain in-depth insight into the unexplored phenomena of PPM expression as AVHs in BPD, we employed a qualitative approach through semistructured interviews (Denzin and Lincoln 2011), conducted as a one-time assessment after participants completed ST. (Initially, we sought participants who had completed the ST programme within the past 12 months. However, due to a lack of participants, we expanded the criteria to include individuals in the final phase of the ST programme and those who had completed it up to 30 months prior to the study.) To properly investigate the subjective experience of the PPM in BPD patients, we employed a systematic, analytical-qualitative content analysis mixed-methods approach (Krippendorff 2018; Schreier 2012), combining inductive and deductive analysis (Braun and Clarke 2006) through semistructured interviews.

Based on the results of previous studies from Cavelti et al. (2021); Kingdon et al. (2010); Slotema et al. (2012) whom found high prevalence of AVHs among BPD patients, we expected that approximately half of the participants would report experiencing AVHs associated with the PPM before their ST treatment, recognizing these as mind-generated phenomena. Additionally, we anticipated that participants would report significant destructive symptoms, characteristic of BPD, such as self-loathing, self-harm, suicidal ideation, self-destructive behaviour, self-punishment (Young, Klosko, and Weishaar 2006) and shame (Jørgensen and Bøye 2024). These symptoms were expected to be linked to the PPM (Young, Klosko, and Weishaar 2006). We anticipated that experiential ST techniques, such as ImRs (Schaich et al. 2020) and ECT (van Maarschalkerweerd et al. 2021), would diminish the power and credibility of the PPM and its associated phenomenology and that this reduction would depend on participants' ability to recognize the connection between past experiences and present problems (de Klerk et al. 2017). We expected that participants would report a decreased influence, dominance and credibility of the PPM and its associated phenomenology following ST treatment (Tan et al. 2018). In cases of AVHs, we anticipated a reduction in the power, control and harmful content of these AVHs or their complete cessation.

Expected outcomes included improved self-understanding, better emotional responses, reduced self-criticism and diminished responsiveness to the PPM's demands. Additionally, we anticipated improvements in physical symptoms, attention and concentration. Furthermore, we predicted that the maintenance of these improvements would be supported by experiences of safety and social connections (Schaich et al. 2020). Recognizing past experiences with pretherapy maladaptive behaviour was expected to facilitate adaptive decision-making and foster a stronger sense of self, distinct from the PPM (de Klerk et al. 2017; Ng et al. 2019; Visser and Arntz 2023). These subtopics aim to deepen our understanding of ST's impact on individuals with BPD, focusing on transforming the PPM and its associated problems.

2.2 | Participants

We recruited participants with a primary BPD diagnosis from the 'Timing of Imagery Rescripting during Schema Therapy for Borderline Personality Disorder' (LUCY) study (Koppeschaar, Bachrach, and Arntz 2023) and the 'Optimal Selection for Borderline Personality Disorder' (BOOTS) study (Wibbelink et al. 2022). The inclusion and exclusion criteria of these studies are presented in Table 1. The participants were drawn from the Academic Center for Trauma and Personality (ACTP) in Amsterdam and GGZ Oost Brabant (Helmond and Oss). All participants completed ST for BPD at these institutions, adhering to established ST protocols (Arntz and van Genderen 2020; Farrell, Reiss, and Shaw 2014). These protocols include a structured number of individual and group sessions, with up to nine patients per group over 25 months. The active ST phase spans 18 months, with weekly group therapy sessions (90 min) and individual therapy sessions (45 min) for the first 12 months, followed by weekly group therapy and biweekly individual sessions for the remaining 6 months. Because the PsyQ location in Amsterdam was closed during their treatment, some participants and their therapists moved to ACTP.

Participants were contacted via telephone or email to assess their willingness to participate in the study. Participation was voluntary, and the participants retained the right to withdraw from the study at any time. The study objectives were communicated to participants verbally and in writing, ensuring they were fully informed. Informed consent was obtained from all participants before their inclusion in the study. Upon receiving signed informed consent forms, follow-up contact was made to schedule the interview session. As compensation for their participation, each participant received a €15 voucher.

We chose a saturation level of 15 participants based on established qualitative research practices emphasizing data saturation and the richness of information obtained from smaller, focused samples (Leavy 2020; Levitt et al. 2018). The final sample comprised 16 participants, including six males and 10 females, with a mean age of 35 years ($SD = 8.67$, range = 24–60). On average, the participants had completed ST 5 months ($SD = 10.33$) prior to the interview, ranging from being in the last 6 months of ST up to 30 months after completion of ST. (The exact start date of this participant's outlier status is unknown due to institutional transitions and privacy regulations. However, the participant

TABLE 1 | Inclusion and exclusion criteria of the BOOTS and LUCY trial studies.

Inclusion criteria	Exclusion criteria
BPD, as defined by the DSM-5, assessed with the SCID-5-PD as the primary diagnosis	DSM-5 substance use disorder that needs clinical detox, according to the clinical staff (after 6 weeks/3 months[a] of abstinence, participation is possible)
BPDSI total score ≥ 20 (i.e., severity in the BPD range; Giesen-Bloo et al. 2010)	Comorbid psychotic disorder (patients with temporary psychotic problems falling under BPD criterion 9 are not excluded (when > 1 year in full remission, inclusion is possible[a])
Between 18 and 65 years old	An antisocial PD with a history of physical interpersonal violence in the last 2 years[a]
Ability to understand, read, write and speak Dutch or English	DSM-5 bipolar disorder, Type 1 (current or past) (if there has been no manic episode in the last year, patients are included[a])
	Acute suicide risk
	IQ < 80
	Serious neurological problems such as dementia
	Patients should not start with any form of psychological treatment during screening, the study's waitlist or treatment (low-frequency [non-PD focused[a]] supportive treatment may be continued during wait and screening but not during the study treatment)
	Not able to commit to group therapy sessions of 90 min and individual sessions of 45–60 min once a week for 2 years within the treatment period.

[a]Exclusion criteria of LUCY trial only.

indicated that they completed ST approximately 2.5 years ago.) For the demographic characteristics of the participants, see Table 2.

TABLE 2 | Demographic characteristics of participants.

	n	%
Gender		
Female	10	62.50
Male	6	37.50
Institute		
ACTP	12	75
GGZ Oost Brabant	4	25
Study		
LUCY	11	68.75
BOOTS	5	31.25
Interview language		
Dutch	10	62.50
English	6	37.50

2.3 | Materials

To develop a semistructured interview protocol, we grounded our open questions in the overarching research objectives and insights from previous studies. Specifically, we employed the Schema Mode Inventory—PPM (SMI-PPM; Young et al. 2007) to understand the cognitive, emotional and behavioural patterns associated with the PPM. Our interview protocol was further informed by qualitative research on BPD and ST (de Klerk et al. 2017; Josek et al. 2023; Schaich et al. 2020; Tan et al. 2018). Additionally, we aimed to probe the phenomenology and intensity of AVHs using questions based on the Psychotic Symptom Rating Scales—Auditory Verbal Hallucinations (PSYRATS-AHV; Haddock et al. 1999). This led to five themes: pretherapy PPM phenomenology, pretherapy PPM impact, therapy experiences, posttherapy experiences and current triggers and coping. After conducting the first four interviews, the first (M.B.) and last author (A.A.) refined the interview based on the insights gained. The final and complete interview guide is in Appendix A.

2.4 | Procedure

The first author (M.B.) conducted the interviews between 8 May and 9 July 2024. Participants were interviewed via Zoom (12 participants), phone (two participants), Microsoft Teams (one participant) and in-person (one participant). The interviews had an average duration of 49 min ($SD = 13.44$, range = 24–76). All interviews were recorded using a Philips Voice Tracer DVT1000. Immediately after each interview, the interviewer made notes of the findings. The audio fragments were transferred from the recorder and stored securely in a protected digital folder on the server of the University of Amsterdam, ensuring confidentiality and compliance with the data protection regulations.

2.5 | Ethics

Ethical approval for this qualitative study was obtained from the Ethics Review Board of the Faculty of Social and Behavioral Sciences, of the University of Amsterdam (FMG-7276). The transcripts of the patients were not shared with their (former) therapists. This was emphasized at the beginning and the end of the interviews. Names and other patient characteristics were deleted from the transcripts. Recordings will be destroyed 10 years after the publication of the main findings.

2.6 | Data Analysis

The interviews were initially transcribed using Transkriptor desktop software (https://transkriptor.com/), providing a preliminary transcription draft. Following this automated process, the first author (M.B.) reviewed and edited each transcript to ensure accuracy and completeness. This manual editing involved relistening all audio recordings to verify the automated transcriptions and correcting any errors or omissions. Identification features, such as the names of the participants, therapists or others, were anonymized during this process to ensure confidentiality.

Building on methodologies outlined by Tan et al. (2018), we employed a systematic, analytical-qualitative content analysis. This approach utilizes inductive and deductive strategies, allowing the exploration of emerging topics and examination of predefined themes aligned with our expectations (Braun and Clarke 2006). Our strategy adhered to the principles of data reduction, emphasizing aspects relevant to our research questions (Schreier 2012).

The transcripts were uploaded into Atlas.ti software (https://atlasti.com/) for analysis. The first two authors (M.B. and P.P.) conducted an independent double-coding process. The coding process was structured around five primary themes based on our expectations: pretherapy PPM phenomenology, pretherapy PPM impact, therapy experiences, posttherapy experiences and current triggers and coping. Each theme comprised various codes and subcodes. Predefined (sub)codes were initially derived from our expectations.

The independent coding process unfolded in three rounds. The first round involved coding the first 10 interviews based on predefined themes and text interpretation. The second round focused on refining the codebook, which was discussed between the first (M.B.) and the last author (A.A.). In the third phase, both coders independently reanalysed the first 10 interviews and then coded interviews 11 through 16. The final round involved aligning the coding with the updated codebook to ensure consistency. This process concluded with the calculation of the intercoder agreement (ICA).

Based on our research aim to explore the PPM experience per individual, the ICA was based on a code's binary presence or absence within a transcript. Due to limitations of Atlas.ti, we used an additional code to compute the ICA, see Appendix B. In line with reliability assessment guidelines for binary coding between coders, we generated a contingency table to compute Cohen's kappa coefficient for each transcript, theme and code (Sim and Wright 2005). The software output included a detailed description of all coded segments for each theme, highlighting coder agreements and discrepancies. We aimed for a minimum achievement and maintenance of Cohen's kappa value of 0.70 for overall and theme-specific intercoder reliability, considered adequate for high intercoder reliability (Landis and Koch 1977). To achieve this minimal ICA level, discrepancies in transcripts and codes were rigorously reanalysed through discussions between coders M.B. and P.P., ensuring a thorough and robust analysis. Overall, the two coders had an ICA Cohen's kappa level of 0.78 ($SD = 0.15$, range = 0.54–0.98) between transcripts. For the ICA levels per theme, see Table 3. The final and complete codebook per theme, including coding and intercoder disagreements, is available in Appendix C, Tables A1–A5.

3 | Results

3.1 | PPM Phenomenology

Participants' pretherapy experiences with the PPM varied widely, encompassing a range of PPM phenomena varying from strong beliefs to hearing voices. These experiences were categorized into several distinct PPM types based on the participant's descriptions, illustrating the complex nature of the PPM.

3.1.1 | Internal Beliefs

Some participants regularly perceived PPM as internal beliefs. For instance, Participant 11 reflected on this experience: 'Um, I think back then it was more thoughts and beliefs'. Similarly, Participant 3 described their PPM as 'more of a force [...] Because it doesn't speak very clearly'. Participant 8 expressed the experience as 'a big block of something hanging down over me', indicating an overwhelming internal presence.

3.1.2 | Intrusive Thoughts

Several participants reported experiencing PPM as intrusive thoughts. Participant 7 noted, 'Well yeah, I did really hear it. But not like a voice, more like just my thoughts. [...] It just sounded like ... It was just my thoughts inside myself, in my head'. This suggests a fuzzy line between thoughts and voices. Participant 9 further illustrated this ambiguity: 'Yeah, it's more of a thought

TABLE 3 | Intercoder agreement for each theme.

Theme	Cohen's kappa
Pretherapy PPM phenomenology	0.78
Pretherapy PPM impact	0.76
Therapy experiences	0.79
Posttherapy experiences	0.75
Current triggers and coping	0.78
Overall	0.78

than ... I didn't hear a voice necessarily. I think maybe once in a while I would'. Participant 10 described her PPM (before treatment) as thoughts and noted that 'sometimes I do talk out loud to myself as a kind of self-soothing, but with negative things'. These experiences highlight how the PPM can manifest internally as intrusive thoughts, with Participant 13 adding: 'It seemed to me as if they were thoughts that I initially controlled or initiated myself, but then I couldn't control them anymore. They took over me. A kind of thoughts that come out loud and then take on a life of their own'.

3.1.3 | Voice-Hearing Experiences

The voice-hearing experiences described by participants varied significantly. Some participants perceived these voices as their own internal monologue. Participant 4 stated, 'No, I have never really heard voices. [...] Because when I think things, I do experience it as if someone is talking to me, but of course, it's just my own voice and no one is actually talking to me'. Participant 6 shared a similar experience: 'I just thought it was my voice. So me saying that to myself and it was very, very strong'.

For other participants, the PPM manifested as distinct, separate voices. Participant 5 recounted, 'I had a voice in my head, I think, like, somebody is talking to me'. Participant 14 provided a similar account: 'very reminiscent of my mom'. These accounts underscore PPM's ability to adopt identifiable characteristics.

Some participants noted that the PPM voice persistently repeated the same messages, as Participant 16 elaborated: 'And that tape just kept playing continuously'. Others described the PPM voice as shouting and screaming or with varying intonations. Participant 14 described 'It's just like shouting in my head ... a very, like, over, like, strong, loud voice', and Participant 12 explained, 'It's really just one voice in my head, just different intonations'.

Several participants reported hearing more than one PPM voice, which could either confirm each other's messages or engage in discussions. Participant 2 described, 'They were voices of old bullies or a father, old teachers, really printed in my head. [...] They engaged in discussions with one another. [...] This was affirmative to each other. That they went into battle with me'. Participant 15 noted, 'No, that was simultaneously directed at me, but at different sound levels. So loud, soft, so you really hear Gods, so to speak'.

Most participants experienced an internal dialogue between the PPM and the self, with the self often adopting a submissive role. As Participant 1 recounted, 'Yes, usually the devil was really speaking to me and then I tried to refute it myself in my own thought'.

3.1.4 | External Voice Hearing

Only Participant 12 reported experiencing external voice hearing in addition to an internal voice: 'Still ... It's all one, but also not ... It came from outside. That was sometime around my twenties ... Between 18 and 20, in a week, that it suddenly started'. Together, these varied experiences underscore the complex and multifaceted nature of PPM, which encompasses internal beliefs, intrusive thoughts and distinct auditory phenomena, both internal and external, and nothing being exclusive within a participant's experience.

3.1.5 | Proportion Hearing Voices

Table 4 presents the *N*s per category of PPM phenomenology. If we take all types of voices into account, 10 out of 16 (63%) reported experiencing PPM at least partially as voice(s). If only voices experienced as from others are considered, the proportion reduces to 50% (8 out of 16). Only one participant (12.5%) reported hearing an external voice.

3.2 | The Impact of PPM

3.2.1 | Daily Impact

The impact of the PPM varied in frequency and intensity among the participants. Some individuals experienced the PPM as constantly intrusive, describing it as a pervasive presence throughout every minute of the day. For instance, Participant 4 described the experience as 'it does feel like I'm

TABLE 4 | Summary of PPM phenomenology across the participants.

Category	Description	*N*
Beliefs	Perception of PPM as internal beliefs or a force without clear articulation.	3
Intrusive thoughts	PPM is experienced as intrusive thoughts, often blurring the line between thoughts and voices.	4
Internal own voice	Hearing voices as an internal monologue, perceived as one's own voice.	2
Internal other voice	PPM manifests as distinct, separate voices with identifiable characteristics, such as resembling familiar people, including persistent messages.	7
Talking out loud	Verbalizing thoughts out loud as a form of self-soothing or coping, with negative or intrusive content.	1
External voice hearing	Experiencing external voice hearing	1

Note: Experiences are not exclusive within a participant.

just standing in one of those busy stations when I'm just by myself. Because there are so many thoughts flying through my head at the same time'. Others reported that the PPM was occasional but highly impactful. Many participants described their PPM as overwhelming and dominating prior to therapy. Often, participants were unaware of the severity and clinical aspects of the PPM before the treatment, leading to a strong identification with it. The severity of the PPM rendered some participants unable to work, either due to or resulting in a lack of structure, creating a cycle where the absence of routine worsened their condition.

3.2.2 | Interaction With Other Modes

Participants described how their PPM interacted with other schema modes, such as the demanding parent, detached protector and compliance surrender mode. In the context of the demanding parent, participants noted that the PPM emerged when demands were not met, intensifying feelings of inadequacy and guilt. Participant 6 explained: 'I guess for the demanding was really to do more, that I wasn't enough, that I had to go ahead again and again. The punitive was that even if I was doing, I was not doing it well'.

A few participants explained how this interaction between the modes created a vicious cycle. The demanding parent pushes to work harder to meet high standards, while the punitive parent criticizes regardless of their efforts. To cope with this internal conflict, some participants withdrew into the detached protector mode, helping them to avoid the emotional pain of constant self-criticism. Simultaneously, the compliance surrender mode compelled other participants conform to the demanding parent's expectations, even when they knew these demands are unattainable. This dynamic illustrates a complex interaction between different modes within participants, reinforcing one another and trapping the client in a cycle of self-punishment and emotional avoidance.

3.2.3 | Emotional and Physical Reactions

Participants reported pervasive feelings of sadness, depression, fear, (social) anxiety, anger and frustration, often accompanied by physical symptoms such as tense muscles in the neck, shoulders and back; headaches; chest tension; stomach issues; restlessness; and panic attacks. These symptoms contributed to chronic stress and discomfort, along with feelings of fatigue and tiredness. Two participants reported chronic health issues, such as rheumatism and Crohn's disease, which they associated to stress from the PPM. Participant 16 stated, 'Well, I developed Crohn's disease in my earlier years. I am 98% convinced that it came from the stress of my youth. That's something I owe to that. Of course, you can never know for sure'.

For some participants, the devastating experience of the PPM and the related feelings of powerlessness were related to suicidal fantasies. For others, the PPM's phrasing implied that they should end their lives. Some participants reported that they experienced apathy due to the PPM, while most participants experienced emotional dysregulation due to the intense emotions evoked by the PPM. Participant 13 explained that being punished for expressing emotions in their youth led to a negative spiral of difficulties with emotional responses and development of a PPM.

3.2.4 | Beliefs and Cognitions

Many participants reported a sense of pessimistic determinism, a self-concept related to the PPM, believing they were inherently bad or had done something wrong in the past and needed blaming themselves. Participant 1 expressed, 'I had the idea that there was some sort of Divine wisdom that constantly had it in for me [...] It was simply because I, yes, I must have done something wrong, it can't be any other way'. For some participants, this belief led to a conviction that ST would not help and that their situation would never change.

While some participants experienced their PPM and its emotional and physical impact as normal, others were aware of the abnormal nature of the PPM and strongly desired change. In addition, several participants experienced fear of failure and possible punishments, as Participant 8 noted, 'The risk assessment would always be like how much I would be punished', which relates to the participants' tendency towards overthinking. In some cases, the PPM was still reinforced by interactions with family members before treatment.

3.2.5 | Behavioural Responses

Participants managed the overwhelming impact of the PPM through a range of maladaptive coping strategies, categorized into forms of overcompensation, avoidance and surrender. Some participants coped by engaging in excessive work, physical exercise or compulsive self-soothing behaviours, attempting to overcompensate the PPM's influence. For instance, Participant 8 described, 'I could easily work for 16 hours a day [...] the only way where I could give myself a little tap on the shoulder as well'. Participant 12 shared, 'training for three hours straight and completely exhausting myself'. Participant 13 engaged in compulsive cleaning, stating, 'I wanted to clean things anew and everything from top to bottom, from left to right; I wanted to clean every single nook and cranny'.

To avoid the distressing impact of the PPM, participants often exhibited impulsive or escapist behaviours. Avoidance behaviours included substance abuse, social isolation and impulsive decisions made to temporarily escape the PPM's influence. Participant 1 noted, 'I became much more impulsive. I didn't think things through [...] Just to think, yeah, I can't deal with this'. Additionally, a few participants mentioned their all-or-nothing thinking, which led to maladaptive coping cycles of behaviour. Participant 9 described their behavioural cycles as 'But it was always switched to whenever things run out of its course and not be so useful anymore and, yeah, it'd be whatever the next thing was'. Some participants reported turning to social media escapism or cycles of binge eating as a distraction. Together, these behaviours reflect a connection with the detached protector, where excessive actions serve as a buffer against PPM's demands.

Certain participants described feeling unable to resist or challenge the PPM, effectively surrendering to its influence. They felt trapped and succumbed to the perceived standards and expectations imposed by the PPM, leading to a passive acceptance of its control over their behaviours and emotions. Participants mentioned surrendering to the demands and not allowing themselves to have fun before these demands were met. Some participants also engaged in forms of self-harm as self-punishment, with one describing cutting herself with glass to cope. Overall, these coping strategies demonstrate varied behavioural responses to the PPM, reflecting patterns of overcompensation, avoidance and surrender.

3.2.6 | Self-Image

Before therapy, participants' self-image was often severely compromised. Many described their self-perception as either nonexistent or extremely negative, with a profound sense of shame and guilt and a persistent fear of being discovered as inherently flawed or unworthy. Participants often viewed themselves as fundamentally different from others, feeling ashamed and guilty about themselves and their PPM symptoms. They felt submissive to the PPM and had a sense of no right to exist. Participant 3 described the sense of being '10 steps behind everyone else' and a demanding need towards conditional acceptance alongside that, 'You have to finish it, you have to do this, you have to do that. [...] Because I thought that then I would be accepted by my family'. In summary, participants' experiences with the PPM not only deeply affected their daily lives and self-perception but also shaped their emotional, physical and behavioural responses, highlighting the pervasive impact of this mode. Table 5 presents a summary of participants' experiences with pretherapy PPM and its impact.

TABLE 5 | Summary of the pretherapy impact of the PPM on the participants.

Aspect	Findings
Daily impact	PPM varied in intensity; some experienced it as constant and intrusive, others as occasional but significant. Often, unrecognized severity led to strong identification with PPM. In severe cases, PPM hinders the ability to work or maintain life structure. Interaction with demanding mode.
Emotional and physical reactions	Emotional distress and dysregulation: sadness, depression, (social) anxiety, anger, frustration, shame, guilt and suicidal fantasies. Physical symptoms: muscle tension, headaches, chest pain, stomach issues and panic attacks. Chronic stress, fatigue and health conditions
Beliefs and cognitions	Pervasive self-blame and pessimistic beliefs about personal worth and changeability. Fear of failure and punishment led to overthinking. Awareness of issues varied; some desired change, others saw PPM as normal, while others felt hopeless.
Behavioural responses	Overcompensation through excessive work, exercise or compulsive behaviours as a means of gaining control. Avoidance behaviours such as substance abuse and social isolation. Others surrendered to the PPM's demands, resorting to passive acceptance or self-punishing behaviours.
Self-image	Severely negative self-perception, unawareness of self and fear of exposure as flawed. Feelings of being fundamentally different from others, fear of being discovered as flawed and striving for acceptance through meeting demanding expectations.

3.3 | ST Experiences

3.3.1 | Scepticism and BPD Diagnosis

Several participants initially approached ST with scepticism, largely induced by their PPM. The revelation of a BPD diagnosis elicited strong reactions, as it often intensified feelings of inadequacy, with Participant 13 describing it as a 'death sentence'. Others perceived ST as a last resort after numerous unsuccessful attempts with other therapeutic modalities and years of striving for improvement while coping with their PPM.

3.3.2 | General ST Elements

Two participants reported that ST was ineffective for them. Participant 4 described the experience as a 'petting zoo ethereal thing', while Participant 7 saw her ST experience as 'a bit of a game. How do I make sure I get through a therapy session without sharing a word with the rest today?' Nevertheless, most participants identified beneficial aspects of ST, such as the opportunity to discuss experiences and emotions. For some, learning to express empathy and communicate emotions was necessary. Participants often mentioned that feeling seen by therapists and peers fostered trust. However, some mentioned feeling unseen during ST. The theoretical framework of ST provided valuable insights, enabling participants to recognize and challenge their PPM messages through checking it with reality and to learn how to function as healthy adults. This involved nurturing their inner child instead of allowing PPM to dominate and understanding the connection between their current modes and past experiences. Despite its benefits, some participants experienced ST as too intense and occasionally too abstract and repetitive.

3.3.3 | Group Therapy

Most participants initially hesitated to engage in group therapy due to social anxiety or negative prior experiences. However, they reported reductions in social anxiety and trust issues, as well as increased recognition and insight through shared experiences. This process reduced beliefs of being bad and different

from others. Although some participants experienced feelings of superiority, disinterest or detachment, the group context generally facilitated positive feedback in combination with checking the PPM with reality and diminished PPM's influence. Several patients reported that the historical roleplay technique was beneficial for them. Overall, most participants viewed group therapy as an ideal setting for overcoming PPM, as these sessions allowed participants to share their experiences and hear from others facing similar challenges, fostering recognition and insight.

3.3.4 | Individual Therapy

Patients experienced the therapist-client relationship as a crucial element in individual therapy sessions. Participants emphasized the importance of being seen and supported by their individual therapist, which was essential for therapeutic progress. Participant 5 recounted, 'Some group sessions were really intense and my therapist, called me at the end of the day, to ask how I was doing, like, I really felt that someone cared about me and this really definitely, improved my situation, like feeling worthy to someone else'. Personalized attention and tailored interventions in individual sessions were crucial for understanding and managing the origins and symptoms of the PPM. Participant 13 stated about her therapist sharing their own life challenges, 'We even talked about her sometimes, which of course isn't really supposed to happen, but it helped me, and she knew that. [...] If you can handle it and if this happens to you too, then I'm not crazy and I'm not alone'. Individual therapy was described as a safe space to discuss personal experiences, focusing on individual needs. The therapist's patience and unconditional acceptance were pivotal in transforming participants' PPM.

3.3.5 | ECT

Participants experienced a multifaceted relationship with ECT. Initial scepticism was common among participants, partly due to PPM's interference, but during treatment many participants found ECT insightful and empowering. ECT facilitated a deeper understanding of internal experiences and dynamics despite initial resistance. The impact of ECT varied between group and individual settings. Participant 2 shared 'Yes, my therapist would often talk to my chairs because I didn't dare to or couldn't do it myself. I found it less tolerable than in the group where it became so empowering'. Participants gained insight and recognition by hearing others express their PPM content. However, this technique was also prone to avoidance through the detached protector. Participant 7 stated 'By the end of therapy, I had done it so often that it became a game for me again: how can I now do this chair technique without caring about it? And then you also know exactly what the therapists wants to hear'.

3.3.6 | ImRs

ImRs was consistently described as insightful, helping participants recognize the link between past experiences and their PPM while addressing emotional needs. This technique significantly contributed to understanding PPM, its origins of self-blame and its impact on emotional well-being. Participant 14 described ImRs as 'seeing and experiencing it is not my fault and having someone else guide you through this process. You get to see it from maybe a fairer perspective than just your own memory'. However, participants reported challenges with the suppression of the impactful memory and the PPM interference. Participant 8 remarked, 'And it's very easy to kickstart, like, a punitive process inside of that. Like, I'm trying to do something good for you, but I just don't remember because I suppressed it so hard'. For some participants, engaging in ImRs was challenging. Participant 13 reported, 'I really had trouble sitting still on a chair and closing my eyes; it made me very nauseous. I felt like everything was spinning'. However, this participant succeeded in processing past experiences through historical role play and doing small imagery meditation exercises. Table 6 provides a summary of participants' experiences with ST.

TABLE 6 | Summary of ST experiences by the participants.

Aspect	Findings
Scepticism and diagnosis revelation	Initial scepticism towards ST and strong reactions to BPD diagnosis, influenced by PPM. Yet, ST was often seen as the last hope after unsuccessful therapy experiences.
General schema therapy elements	Two participants found ST ineffective. ST theory provided insights into PPM and how to act as a healthy adult and care for the inner child. Effective aspects included discussing experiences/emotions and learning empathy. Participants felt seen by therapists and peers, building trust. Some found ST too intense, abstract and repetitive.
Group therapy	Initial hesitation due to social anxiety or negative past experiences but reduction in social anxiety and trust issues. Increased recognition and insight through shared experiences. Some feelings of superiority, disinterest or detachment. Group therapy was mentioned as most effective through checking PPM with reality and positive feedback.
Individual therapy	Personalized unconditional acceptance, attention, patience and tailored interventions were essential for understanding PPM's origins. It provided a safe space for discussing personal experiences.
ECT	Initial scepticism but found insightful and empowering. Facilitated understanding of internal experiences and dynamics. The impact varies between group and individual settings and is prone to avoidance by detached protector.
ImRs	Described as insightful, linking past experiences to PPM and helped address emotional needs and reduce self-blame. However, challenges with memory suppression and PPM interference.

3.4 | Post-ST Experiences

3.4.1 | Changes in PPM Phenomenology

Participants described changes in understanding and managing their PPM experiences following ST. Enhanced recognition of their experiences empowered participants to exert greater control over the PPM. Participant 12 noted about the relation between PPM and self that 'Then it happened all at once, the big voice became smaller and the small voice somewhat larger'. Techniques such as checking their PPM messages with the reality and positive feedback in therapy sessions facilitated participants' ability to recognize the lack of credibility of PPM messages. Moreover, ST offered some participants awareness into their PPM beliefs and thoughts, allowing them not only to gain better insight but also to articulate and later adapt these thoughts more effectively. As Participant 11 stated, 'I think schema therapy has given me the ability to, like, put those thoughts and feelings into words now'.

Several participants reported a sense of disconnection from the PPM and that the intensity and frequency of the experiences diminished. For instance, Participant 5 remarked, 'Sometimes I hear it in my head, but most of the time I think it's more distant'. Participant 3 similarly noted, 'The volume is also very, very low. You can just hear it sometimes'. Participant 2 described, 'Every day, multiple times a day, I used to hear punitive messages, but now it's once a day'. Participant 15 explained, 'I don't hear a hundred voices at the same time, but just ... It's like it's sitting here somewhere, not in my head anymore, but just somewhere around'. While these participants note that the PPM voice is more distant from the head, they did not attribute the voices externally. However, for some, the raised awareness increased the frequency and intensity of the PPM after ST. This suggests that while some participants continued to experience PPM messages, they reported a growing ability to question and dismiss them.

3.4.2 | Changes in Symptoms

After therapy, participants reported notable improvements in emotional regulation, mood and behavioural symptoms. They experienced significant reductions in substance abuse, suicidal fantasies, impulsiveness and physical symptoms that previously were associated with the PPM. Additionally, participants experienced enhanced self-awareness and emotional management, increased empathy, a greater hope for the future and reduced self-criticism. However, some participants who exhibited apathy prior to ST reported heightened emotional responses and mood fluctuations afterward, which they currently struggle to regulate.

3.4.3 | Relationship With PPM

The relationship with the PPM evolved significantly during therapy, reflecting a transition from identification with and domination by the PPM to a state of de-identification and eventual reduction of the PPM's impact on daily life. Participant 8 reflected on this transition, stating 'Why are you more mourning something that is so bad for you? But then, at the same time, I also understand why I'm mourning it because it's something that's been part of you and kind of trying to say goodbye to it'.

Many participants reported that they believed they would never get rid of the PPM and needed to accept it. Participant 13 shared an acceptance strategy: 'There was a woman who once said, in my group, "I try to look at it like this. I see it as a hot flash. Oh, there's another one. It will pass soon enough."' Participant 16 described the gradual reduction of the PPM's presence, stating, 'It's not gone yet. I don't think it will ever completely go away. But it's just wearing away, you know. It's all becoming much softer and calmer'. These reflections suggest that, while participants may not fully eliminate the PPM, acceptance is crucial to managing its influence.

Interfering the PPM was an important technique in dealing with the PPM. Participant 3 noted, 'Yeah, go back to your corner. Sometimes it still feels like ... like I have it on a leash, and it's still in my ear, you know, like ... Okay, this is annoying, but at least it's not inside me anymore'. Additionally, Participant 2 shared about the voices that 'They are still present, but I can just learn to deal with them so that I can work with them ... If I have to make decisions, okay, what does everyone think? Instead of them being against me'. Table 7 presents a summary of participants' post-ST experiences.

TABLE 7 | Summary of the post-ST experiences.

Aspect	Findings
Changes in PPM phenomenology	Participants gained significant insight into PPM, enhancing their ability to manage and control these experiences. Checking with reality and positive feedback helped participants recognize the lack of credibility in PPM messages. Participants reported a reduction in the intensity and frequency of PPM experiences.
Changes in symptoms	Participants reported a notable reduction in physical, emotional, and behavioural symptoms, including decreased impulsiveness and mood disturbances. They also experienced enhanced emotion regulation, increased empathy and heightened self-awareness. Additionally, there was a significant increase in hope and a decrease in self-criticism, which contributed to fostering greater self-compassion.
Relationship with PPM	Transition from identification with PPM to de-identification and reduced impact on daily life. Some participants experienced a sense of mourning as they distanced themselves from PPM, highlighting the complex relationship with this mode. Acceptance emerged as a crucial component in managing PPM, with participants learning to coexist with residual occurrence.

3.5 | Current Triggers and Coping With PPM

3.5.1 | Triggers

The participants mentioned several key triggers for the PPM post-ST. The participants mentioned social and interpersonal relationships as significant PPM triggers, alongside a several participants mentioned activation by unmet emotional needs and violation of boundaries. Participants noted that previous maladaptive coping mechanisms, such as substance abuse and isolation, perpetuated the PPM by creating a feedback loop. Other notable triggers included loneliness, performance and the alongside possible failure and contact with family members. Overall, participants mentioned that activation of the PPM was still situation or mood dependent.

3.5.2 | Adaptive Coping Strategies

Following therapy, participants adopted a variety of adaptive coping mechanisms to manage the PPM effectively. These strategies included interfering the process with talking back to the PPM, strengthening the healthy adult self and nurturing the inner child, employing adaptive self-soothing techniques and setting boundaries. Participant 5 described an inner child technique learned in ST: 'The thing is I try to talk to myself. When I go to bed, I imagine this in my mind, like there's this child, like I see myself, I try to soothe it, it's okay that this thing happened'. Participant 2 reported using ECT as a tool that she could use at home to cope with mode activation: 'If things get too intense in my head, I just set up chairs in the living room'. Most participants engaged in adaptive flexible decision-making in line with their emotional needs and long-term goals highlighting it as a crucial strategy for navigating daily challenges. A few participants mentioned avoidance as an adaptive coping strategy, indicating a shift towards actively ignoring the PPM.

3.5.3 | Supportive Factors

Several factors emerged as crucial supportive factors in reducing the impact of the PPM. Social support and feedback, recognition of the unmet needs in the past and their effect on present experiences, and making healthy choices that align with emotional needs were significant contributors to participants' well-being. Participant 15 learned to observe the PPM in others in their own environment and stated that 'And I recognize what you really do to yourself and how that world doesn't actually play out in your head. Because no one else is as angry at you as you are. Oh yeah, you're really suffering because of yourself'.

Improvements in self-image were a notable outcome post-therapy, with participants experiencing enhanced self-understanding, self-acceptance and compassion. Developing a robust sense of self and self-worth led to an improved self-image, diminishing the influence of PPM and enhancing overall well-being. The participants no longer identified themselves with the PPM and no longer saw themselves as submissive to the PPM. Considering the participants' future goals, they expressed a desire to automate healthy adult behaviours and relinquish the associated compulsive control, with many aiming to let go of the PPM.

3.5.4 | Feedback on ST

Participants provided feedback indicating a desire for continuation of therapy and more guidance in finding a follow-up treatment. The wish to continue therapy stemmed from an experienced lack of knowledge and repertoire of healthy adults' behaviour and possibility in dealing with negative memories. Two participants wished they knew that they could have called with their therapist after intense sessions, while another suggested a more careful introduction of exercises to combat demanding and punitive messages. Participants requested additional reading materials and expressed a desire to learn how to recognize the PPM outside of GST, particularly within their own social interactions and environments, to further support their progress. Table 8 provides a summary of participants' current triggers and coping mechanisms related to PPM.

TABLE 8 | Summary of the triggers and supportive factors in dealing with PPM experienced by the participants.

Aspect	Findings
Identified triggers	Social and interpersonal relationships, loneliness, (previous) maladaptive coping mechanisms, unmet emotional needs, violation of boundaries, performance or failure, contact with family members and situational or mood-dependent factors.
Adaptive coping strategies	Interfering with PPM, strengthening the healthy adult self and taking care of the inner child, adaptive self-soothing and decision-making and using ECT as a coping tool.
Supportive factors	Social feedback and support, recognition of the impact of the past on present experiences, improved sense of self, positive self-perception, diminished PPM influence through enhanced self-understanding, acceptance and worth. Yet, there is a desire to automate healthy adult behaviours and fully let go of PPM and control.
Feedback on schema therapy	The patients desired continued therapy and guidance for follow-up treatment, wanted to know about postsession support availability, suggested careful exercise introduction and requested additional reading materials and insights into healthy adult behaviour.

4 | Discussion

This study aimed to investigate the experiences of (ex)patients who received ST for BPD, focusing on changes in the PPM and its potential manifestation as AVHs. The primary objective was to explore the subjective experiences of the PPM in BPD patients before, during and after ST, assessing the transformation of these experiences through therapy and examining the impact of ST techniques on mitigating the PPM and possible related AVHs.

The findings supported our expectation that approximately half of the participants would experience AVHs linked to the PPM before ST, illustrating a range of PPM phenomenology, including beliefs, thoughts and distinct auditory experiences. While not all participants experienced AVHs, those who did experienced them to be a significant and troubling aspect of the PPM. Nevertheless, the identification of AVHs remains definition-dependent, varying with the criteria used to classify these experiences (López-Silva, Cavieres, and Humpston 2022; Telles-Correia, Moreira, and Gonçalves 2015). Note that with a strict definition (the voice should be heard outside one's head), only 1 of 16 participants reported AVHs that would qualify for a psychotic symptom. Remarkably, while loss of reality testing is central in the definition psychosis (APA 2022), this criterion seems seldom used when it comes to voice hearing. The consequence is that people who hear voices but correctly attribute them to their own mind are classified as suffering from psychotic experiences. The underlying, but questionable idea, might be that if one knows that a phenomenon is produced by one's own brain, it is not sensorially experienced (e.g., musicians who hear music in their imagination would be psychotic). Different conceptualizations of AVHs may influence the reported prevalence and nature of these phenomena within BPD populations (D'Agostino, Rossi Monti, and Starcevic 2019).

As expected, participants frequently described their pretherapy experiences with the PPM as overwhelming and dominating, contributing to intense self-criticism and self-blaming. These experiences often included emotional and physical distress and maladaptive coping strategies that significantly impacted their daily lives and self-perception. The study corroborated the expectation that ST techniques, particularly ImRs and the ECT, would reduce the power and credibility of the PPM and its associated phenomenology, including AVHs. Participants reported gaining insights into their PPM and experiencing reduced dominance and credibility. This reduction in voice hearing through ImRs has also been observed in individuals experiencing AVHs within psychotic disorders (Paulik, Steel, and Arntz 2019; Paulik et al. 2022; Strachan et al. 2023). Contrary to earlier literature, the benefits of group therapy sessions within the ST framework were also highlighted, as these sessions allowed participants to share their experiences and hear from others facing similar challenges, fostering recognition and insight. Posttherapy, participants noted a significant decrease in the intensity and frequency of PPM experiences, including those with AVHs, and reported improved emotional regulation, self-understanding and self-compassion.

Participants also reported a transition from identification with and domination by the PPM to a state of de-identification and eventual reduction of the PPM's impact on daily life. Acceptance emerged as a crucial component in managing the PPM, with participants learning to coexist with residual messages without allowing them to dominate their self-concept. The sustainability of these improvements was supported by participants developing healthier coping mechanisms and an improved self-image, aided by social support, feedback and the recognition of past experiences. The narratives indicated that social and interpersonal relationships, maladaptive coping mechanisms, certain moods and situations of performance and failure were still critical in PPM's activation.

One notable limitation of this study is the potential for hindsight bias, as we interviewed the participants in their final phase or after the completion of ST. This timing means that participants' reflections on their experiences and changes might be influenced by their current state and retrospective interpretation through theoretical framework of ST (Fischhoff 1975), potentially affecting their perceptions of the PPM and associated AVHs before ST. Additionally, patients who derived the most benefit from and were highly engaged with ST might have been more likely to participate, potentially introducing selection bias. To mitigate these biases in future research, we recommend conducting interviews before, during and after treatment. Additionally, relying on self-reported data through semistructured interviews may have introduced social desirability or recall bias (Fisher 1993; Bradburn, Rips, and Shevell 1987), as participants might have altered their descriptions due to the stigma surrounding BPD and AVHs (Aviram, Brodsky, and Stanley 2006; Volpato et al. 2022). Future research could incorporate multiple data collection methods, including quantitative clinical assessments and longitudinal follow-ups, to provide a more nuanced understanding of changes in the PPM and possible related AVHs.

Another key limitation of our study is the exclusion of BPD individuals who meet the criteria for comorbid psychotic disorders. While patients with transient psychotic symptoms, as defined by Criterion 9 of the DSM-5 for BPD, were included in both trials, this exclusion may reduce the generalizability of our findings. Specifically, our study may not fully capture the diverse spectrum of BPD experiences, particularly considering ongoing debates about the potential (mis)diagnosis of AVHs as comorbid psychotic disorders (Beatson et al. 2019). Emerging perspectives suggest that positive symptoms like AVHs might span across diagnostic categories, reflecting a broader continuum of psychosis rather than discrete disorders (van Os and Reininghaus 2016; van Os et al. 2009). To enhance our understanding and improve treatment approaches for this complex population, future research should explore psychotic experiences in BPD beyond the constraints of the DSM-5 framework. A crucial first step would be to investigate individuals with BPD who also have comorbid psychotic disorders.

Considering the clinical considerations of this study, it is crucial to recognize that the PPM can occur as AVHs, which has important consequences for providing comprehensive treatment to individuals with BPD. Integrating this understanding into ST can enhance its effectiveness by addressing the specific phenomenology of AVHs. The findings underscore the transformative

potential of ST in alleviating distressing symptoms associated with the PPM, such as AVHs, and highlight the need for further research to refine therapeutic approaches for this population. Participants reported reduced intensity, frequency and credibility after ST. Key techniques such as 'talking back' from ECT, strengthening the healthy adult mode nurturing the inner child and setting aside positive experiences were instrumental in achieving these improvements. Additionally, patients learned to accept the PPM as part of their experience and developed strategies for managing it.

However, participants noted that the PPM could still be triggered by certain moods or situations, such as stress and situations of performance with possible failing alongside, and interaction with family members. In these situations, maladaptive coping mechanisms, such as substance use, often resurfaced, further contributing to the reactivation of the PPM. To prevent a negative spiral, we advise to integrate a relapse prevention plan in ST. This PPM management plan (Farrell, Reiss, and Shaw 2014) should focus on identifying triggers that may reactivate the PPM after treatment and on strategies to prevent relapse. Based on the study's findings, key elements of the plan should focus on continuing the practice of 'talking back' to the PPM as in ECT, strengthening the healthy adult mode, nurturing the inner child to process stressful or traumatic memories and developing the ability to recognize the presence of the PPM in daily interactions outside of treatment.

In conclusion, this study underscores the potential manifestation of the PPM as AVHs and demonstrates the effectiveness of ST in addressing these symptoms in patients with BPD. Our findings show that a significant portion of participants experienced AVHs linked to the PPM prior to therapy, underscoring the distressing nature of these symptoms. Notably, ST techniques, particularly group therapy, ImRs and ECT, significantly reduced the intensity and frequency of PPM-related experiences. While the AVHs did not completely disappear, these participants reported as well less intensity, frequency and credibility of this PPM manifestation. Participants reported improvements in emotional regulation, self-understanding and self-compassion, along with a shift from identifying with the PPM to developing a more balanced self-concept. Enhanced social support networks and adaptive coping and decision-making strategies further facilitated this transition. Future research should expand data collection methods and consider a wider range of psychotic(-like) experiences within BPD to refine therapeutic approaches further. These findings emphasize the importance of integrating an understanding of AVHs into ST, paving the way for more comprehensive and effective relapse prevention strategies for BPD patients.

Author Contributions

Mariëlle C.E. Baelemans: conceptualization, methodology, software, validation, formal analysis, investigation, resources, data curation, writing – original draft, visualization. **Puk Plooij:** formal analysis, validation. **Nathan Bachrach:** data curation, writing – review and editing. **Arnoud Arntz:** conceptualization, methodology, supervision, writing – review and editing.

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Conflicts of Interest

A.A. publishes about Borderline Personality and Schema Therapy in scientific articles, books and book chapters and occasionally gives workshops on this treatment. The financial remuneration he receives goes to the University of Amsterdam to support research. A.A. received grants for research into the (cost-)effectiveness of treatment of borderline personality disorder. N.B. publishes about borderline personality and schema therapy in scientific articles and book chapters and occasionally gives workshops on this treatment. N.B. provides supervision about schema therapy for which he receives financial remuneration. N.B. received grants for research into the (cost-)effectiveness of treatment of borderline personality disorder. The other authors declare that they have no competing interests.

Data Availability Statement

The data are not publicly available due to privacy and ethical restrictions.

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Appendix A

Interview Guide

Semistructured interview questions.

Examining the subjective experiences of the Punitive Parent Mode in Borderline Personality.

Disorder individuals following Schema Therapy.

A.1 | Introduction

In this study, I would like to learn more about how people experience punitive mode. Previous research shows that about half of people with borderline personality disorder experience this punitive mode as if it were a real voice giving criticism. I'm curious about how you experienced this mode, both before, during and after your treatment with schema therapy. First, is it okay for you that I call it the punitive mode? From now on, I will call it whatever you want. I will ask you questions about your behaviour, feelings, emotions and physical reactions that you experience in punitive mode. If you have experienced or are experiencing things that I do not mention, please name them. My goal is to understand your experiences better so we can learn how schema therapy helps deal with this mode and improve the therapy to help people even better in the future.

Moreover, knowing that you can say everything in this interview is necessary is essential. It is about your experience; there is no right or wrong answer. In addition, it is okay if some of my questions evoke emotions in you. Of course, you may indicate and take a break anytime, and you do not have to answer every question I ask. Lastly, please rest assured that nothing you share in this conversation will be disclosed to your therapists.

1. Experiences before treatment with the punitive mode
   a. Can you describe your experiences with what you now recognize as the punitive mode? How did you become aware of its presence in your life?
      i. What specific thoughts, words or beliefs or behaviours do you associate with this mode?
      ii. What emotion(s) did this mode evoke in you?
      iii. Were physical sensations associated with it?
      iv. How did you deal with it at the time? What was your coping?
      v. How did the punitive mode influence your decisions and actions at the time?
      vi. What kind of self-image did you have at the time?
   b. Did you identify the punitive mode primarily as thoughts or as a voice you *heard*?
      i. Did you perceive one or more punishing modes?
      ii. In case of more: How were they similar or different? Can you describe any interaction they may have had with each other? For example, did they contradict or reinforce each other?
      iii. Did these thoughts or voices seem to come from inside you, or did they seem to come from outside you?
      iv. What was the role of your own 'voice' versus the punishing mode? How did it contrast with the punishing mode?
      v. Did the punitive mode voices/thoughts already remind you of anyone at the time?

2. Changes due to Schema therapy
   a. What was undergoing schema therapy like for you?
   b. Are there any specific aspects of schema therapy that have been particularly impactful in changing your experience of the punitive mode?
      i. Elements of group therapy? The experience of the group? and the techniques that were used? And the role of the therapists?
      ii. In individual therapy, the role of the therapist and techniques? Such as imaginary rescripting, the empty chair technique?
   c. How has your experience of the punitive mode changed while undergoing schema therapy?
      i. Can you give examples of how it changed your perceptions, your thoughts about, the voices, emotions or your behaviour?

3. Experience with the punitive mode after treatment
   a. How do you currently experience the punitive mode, after treatment?
      i. Can you talk more about any changes compared to before and during treatment?
      ii. How has the intensity and frequency changed? Can you give examples from before treatment and now?
      iii. Do you still have physical symptoms?
   b. How has your understanding and recognition of the punitive mode changed your experience of it?
      i. Do you feel that you have more control over the punitive mode now than before treatment?
      ii. How true are the messages of the punishing mode for you now?

4. Maintaining factors and current management
   a. What factors contribute to the persistence of the punishing mode in your life?
      i. What kinds of situations or events trigger the punitive mode?
      ii. How do you deal with this mode now when it resurfaces? Compared to before and during with before treatment?
   b. Are there specific thoughts, situations or behaviours that seem to reduce this mode?
      i. For example, how do social support, recognizing a connection between past and present and your current way of making choices play out.
   c. How is your current relationship with the punitive mode?
      i. What kind of self-image do you currently have?
      ii. What are some things you would like to improve now to better cope with the punishing mode?

5. Experience interview
   a. Are there any things you have experienced in this process that you would like to share or that you yourself think are still important to mention?
   b. How did you experience this interview?
      i. What was it like to talk about your punitive mode and experiences with schema therapy?

Appendix B

Python Code Used for ICA Computations

```
import pandas as pd
import numpy as np
from sklearn.metrics import cohen_kappa_score
import scipy.stats as stats
import ace_tools as tools

# Load the Excel file
file_path = "
data = pd.read_excel(file_path, sheet_name='CodeDocumentTable')

# Extract relevant columns for each coder
mb_columns = [col for col in data.columns if col.startswith('MB.')]
pp_columns = [col for col in data.columns if col.startswith('PP.')]

# Ensure columns are paired by their numeric identifier
mb_columns.sort (key=lambda x: int(x.split('.')[1].split('\n')[0]))
pp_columns.sort (key=lambda x: int(x.split('.')[1].split('\n')[0]))

# Function to calculate Cohen's kappa and its confidence interval
def calculate_kappa_and_ci(mb_ratings, pp_ratings):
    kappa = cohen_kappa_score(mb_ratings, pp_ratings)
    n = len (mb_ratings)
    se = np.sqrt((1 - kappa**2) / (n - 1))  # Standard error for kappa
    z = stats.norm.ppf(0.975)  # z-score for 95% confidence
    ci = (kappa - z * se, kappa + z * se)
    return kappa, ci

# Dictionary to store results
kappa_results = {}

# Concatenate all ratings for overall kappa calculation
all_mb_ratings = []
all_pp_ratings = []

# Calculate Cohen's kappa and confidence interval for each pair
for mb_col, pp_col in zip (mb_columns, pp_columns):
    mb_ratings = data[mb_col]
    pp_ratings = data[pp_col]

    # Store all ratings for overall kappa calculation
    all_mb_ratings.extend (mb_ratings)
    all_pp_ratings.extend (pp_ratings)

    # Calculate kappa and confidence interval
    kappa, ci = calculate_kappa_and_ci(mb_ratings, pp_ratings)

    # Generate contingency table
    contingency_table = pd.crosstab (mb_ratings, pp_ratings)
    # Store the results
    kappa_results[mb_col] = {
        'kappa': kappa,
        'confidence_interval': ci,
        'contingency_table': contingency_table
    }

# Calculate overall Cohen's kappa and confidence interval
overall_kappa = cohen_kappa_score(all_mb_ratings, all_pp_ratings)
n_total = len (all_mb_ratings)
overall_se = np.sqrt((1 - overall_kappa**2) / (n_total - 1))  # Standard error for overall kappa
overall_ci = (
    overall_kappa - stats.norm.ppf(0.975) * overall_se,
    overall_kappa + stats.norm.ppf(0.975) * overall_se
)

# Combine individual and overall results
overall_kappa_summary = {'Overall': {'kappa': overall_kappa, 'CI': overall_ci}}
```

```
combined_kappa_results_summary = pd. DataFrame({
    **{col: {'kappa': res['kappa'], 'CI': res['confidence_interval']} for col, res in kappa_results.
items()},
    **overall_kappa_summary
}).T

# Display the results
tools.display_dataframe_to_user(name="Combined Cohen's Kappa Results Summary",
dataframe=combined_kappa_results_summary)
```

Appendix C

Codebook per Theme Alphabetically, Including Coding and Intercoder Disagreement

TABLE A1 | Codes, coding and intercoder disagreement of Theme 1: Pretherapy PPM phenomenology.

Code and subcode	Description	Participant															Total
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
Amount																		
Multiple PPM	The client reports that there are different PPM voices or origins		*			*				1	1					1		3
One PPM	The client reports hearing only one PPM 'voice' or origin		*		*	*		1	1	*	1	*	1	1	1		1	7
Interaction																		
Confirmation	In case of multiple PPMs, the client reports that the PPMs confirm each other									1						1		2
Discussion	In case of multiple PPMs, the client reports that the PPMs discuss	*	*		*	*	*			1								1
Internal conflict/ dialogue with self	The client reports experiencing an inner conflict of dialogue between self and the PPM	1	*	1	1	*	1		1	1	1	1	1	*				9
Location																		
External voice	The client reports that the PPM is external to the self									*			1					1
Internal voice	The client reports that the PPM is stemming from internally	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	*	15
Appearance																		
Different intonations	The client reports that they experience the PPM voice with different intonations				*								1	1		*	*	2
Repeating	The client reports experiencing the PPM as repeating the same message															1		1
Shouting/ screaming	The client reports experiencing the PPM as shouting or screaming at them												1		1	*		2
PPM expression																		
Beliefs	The client reports the PPM mainly as beliefs			*			*	*	1	1	1	1						4
Hearing voices	The client mentions the PPM as an actual voice they hear		*							*						1		1
PPM talking out loud	The client mentions that they say the PPM messages out loud to themselves					*					1							1
Thought voice	The client reports the PPM as a voice but describes it as their thoughts					*	*	*	*					*			1	1
Thoughts	The client reports the PPM as thoughts									1		*					1	2

Note: 1 indicates both coders coded the code in the document, * indicates only one coder coded the code in the document and '' indicates the code is not coded in the document. Total indicates the amount of code double coded in the documents.

TABLE A2 | Codes, coding and intercoder disagreement of Theme 2: Pretherapy PPM impact.

Code and subcode	Definition	Participant															Total
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
Behaviour																		
ADHD symptoms	The client reports an interaction between the PPM and ADHD symptoms									1	*			*				1
Behavioural swings	The client reports experiencing behavioural all-or-nothing swings			1			*	1				*			*	1		3
Binge eating	The client reports episodes of binge eating as a way of coping with PPM	*				1				1		1						3
Breaking things	The client reports breaking things out of anger outbursts stemming from PPM															1		1
Compulsive behaviour	The client reports compulsive behaviour as a way of coping with PPM								1					1	1	1		4
Self-harm	The client reports cutting, scratching or other ways of self-harming themselves as a way to cope with the PPM															1		1
Distraction	The client reports distracting themselves from the PPM, through (social) media for example								1	1		1			1			4
Impulsivity	The client acts on impulse due to PPM influence/raised emotions	1	1		1	1		1	1		1			1	*	1		9
Isolation	The client isolates themselves to escape PPM (triggers)			1		*		*		*	1	1	1	1	*		1	6
No boundaries	The client struggles with maintaining personal boundaries due to PPM						*				1					1	1	3
Other maladaptive self-soothing	The client reports other self-soothing strategies						1	1								1		3
Self-sabotage/ destructive	The client engages in self-sabotaging and destructive behaviours influenced by PPM					1		*							1	1		3
Substance abuse and addiction	The client uses substances to cope with PPM, such as alcohol, weed, caffeine and drugs	1	1		1	1	1	*	1	1	1	1	1	1	1	1	1	14
Taking revenge	The client reports (thinking of) acts of revenge on others influenced by PPM					*											1	1
Beliefs and cognition																		
Being stuck in life	The client feels unable to progress in life due to PPM			*	1							*			*			1
Cognitive paralysation	The client reports cognitive paralysis due to PPM		1	1			1		1		1	1	1	1				8
Conditional acceptance	The client feels accepted only under certain conditions dictated by PPM or demanding parent			1				1			1					1	1	5
Distrust to others	The client experiences distrust towards others influenced by PPM	1			1										1		1	4
External confirmation PPM	The client experiences confirmation of PPM by surroundings					*	1	1	1	1	1					1	*	6
Fear of failure	The client fears failing due to PPM pressure		*		1				1		1		1					4
Memory suppression	The client suppresses memories related to PPM experiences								1			*	1					2

(Continues)

TABLE A2 | (Continued)

Code and subcode	Definition	Participant																Total
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
No right to be	The client feels they have no right to exist due to PPM	*		1		*	1	1	1	1	*					1	*	6
Overthinking	The client overthinks due to PPM influence	*	*	1	1	1					1		1	1				6
Pessimistic determinism	The client believes negative outcomes are inevitable due to PPM	*			1		*			1	1		1					4
Punished for experiencing emotions	The client feels punished for having emotions										1							1
Scared to be discovered	The client fears being discovered or exposed due to PPM	*		1			*					*	*				*	1
Self-blaming	The client blames themselves for events or emotions	1	*	1		1	1	*			1	*		*	*	1		6
Unawareness of PPM	The client is unaware of the influence of PPM in their life		1	1		1	*	1		1	1	1			1			8
Wanting to change	The client expresses a desire to change despite PPM influence		*	1		*					1	*	1	*	*	*	*	3
Coping																		
Avoidance	The client avoids situations or thoughts related to PPM	1	1	1	1	*	*	1	1	1	1	*	1	1	1	1	*	12
Dissociation	The client dissociates as a coping mechanism for PPM		1			1			1	1			1					5
Overcompensation	The client overcompensates to counteract PPM					1	*	1	1		1	1	1	1	1			8
Surrender	The client surrenders to the PPM influences			1				1	1	*		*			*			3
Daily life																		
High functioning	The client maintains high functioning despite PPM	*						1										1
Unable to work	The client is unable to work due to PPM			1	1					*				1			1	4
Lack of structure	The client struggles with maintaining structure due to PPM			1							1							2
Relationship problems	The client experiences relationship issues due to PPM		*	1		*	*							*	*	1		2
Emotions and moods																		
Anger and frustration	The client experiences anger and frustration towards the PPM	1	1		1	1	1	1		1	1	1	1	1	1	1	1	14
Apathy	The client feels apathetic/suppresses emotions due to PPM influence			1	1	*	1	*	1		1		1		*			6
Emotion dysregulation	The client experiences difficulty regulating emotions due to PPM	1	1		1		1	*			1	1		1	*	*	*	7
Fear and anxiety	The client experiences fear and anxiety due to the PPM		1	1		1	1	1	1	1	1	1	1	1	1		1	13
Feelings of emptiness	The client reports feelings of emptiness due to the PPM			1			1			1								3
Overwhelmed by PPM	The client is overwhelmed due to the severeness of the PPM			*	1	*	1		1		1		1		*	*	*	5

(Continues)

TABLE A2 | (Continued)

Code and subcode	Definition	Participant															Total
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
Sadness and depression	The client experiences sadness and depression due to the PPM	1			1		1	1	1	1	1	1	1	1	1	1	1	13
Shame and guilt	The client is ashamed or feels guilty due to the PPM		1	1		1		1	1					1	*	*		6
Suicidal fantasies	The client reports experiencing suicidal fantasies due to the PPM		1				1	*			1		1	1			1	6
Interaction with other modes																		
Compliance surrender	The client reports interaction between the PPM and the compliance surrender mode								1	1				*				2
Demanding parent	The client reports interaction between the PPM and demanding mode		*	1			1	*	1	1	1	1	1	*		1		8
Detached protector	The client reports interaction between the PPM and the detached protector mode			1				1		1		*						3
Physical symptoms																		
Chronic health issues	The client reports general chronic health issues related to PPM									*	1						*	1
Fatigue and tiredness	The client reports fatigue and tiredness related to PPM									*			1		1			2
Heart/chest problems	The client reports heart or chest problems due to PPM	1		1		*	*	*		1	*			*	1	1		5
Neck, shoulder, back and headaches	The client reports tension in neck, shoulder, back or headaches due to PPM		1	1		*						*		1		1		4
Other high-stress level symptoms	The client experiences high-stress symptoms	1	1	1	1	1	*		1		*	1	1	*		1	*	9
Panic attacks	The client experiences panic attacks related to PPM		1					1	1		1	1		1		1		7
Restlessness	The client feels restless due to PPM influence				1		*			*	1	*		*		1		3
Stomach issues	The client experiences stomach issues related to PPM					*	*					1					*	1
Self-image																		
Different than others	The client feels different from others due to PPM	1	*	1	1	1			1	1		1	1	1				9
Dominated by PPM	The client feels dominated by PPM	1	1	1	1	1	1	1	1	1	1	1	1	1	1		1	15
Grandiose	The client experiences (episodes of) grandiose thoughts influenced by PPM					1							1					2
Identification with PPM	The client identifies with the PPM messages		*	1			1	1	1	1	1	*			*	1		7
Unstable sense of self	The client has an unstable sense of self due to PPM				1	*			1	*					*			2
Negative self-image	The client has a negative self-image influenced by PPM	1	1		1	1	1	1		1	*	1	1	1	1	1	1	13
No sense of self	The client feels they have no sense of self due to PPM						1		1	1	1	1					*	5
Submissive self	The clients feel submissive to PPM and others	1		1		*		*	*	1		*	1	1	*	1	*	6

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TABLE A3 | Codes, coding and intercoder disagreement of Theme 3: ST experiences.

Code and subcode	Definition	Participant																Total
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
ECT																		
Insight through ECT	The client gains insight into PPM mechanisms through ECT therapy	*	1	1		1	1	*	1	*	1	1	1		1	1	*	10
Scepticism ECT	The client is sceptical about the use and effectiveness of ECT	1	*	1	1	*	1		1	1		1			1		1	9
Unable to do ECT	The client is unable to participate in ECT due to various reasons													1				1
Entering ST																		
ST as last hope	The client sees schema therapy as a last resort						1			1	1						1	4
Scepticism ST	The client is sceptical about schema therapy	1			1	*			1	1		*		1	1			6
Stigma BPD diagnosis	The client experiences stigma-related thoughts about their BPD diagnosis.				1									1				2
General ST elements																		
Ability/learn to talk about experiences and emotions	The client learns to express emotions and experiences	1	1	1	1	1		1	1	1	1	*	1		*	1	1	12
Being seen by therapist(s)	The client feels seen and understood in therapy	1	1	1		1	1	*	1		1	1	1	1	*	*	1	11
Earning trust	The client builds trust through interaction with peers and therapists	1						*									*	1
General insight through ST	The client gains general insights through schema therapy	*	1	1		1	1	1	1	1	1	1		*	*	1	*	10
Healthy adult	The client learns about and develops a healthy adult mode	1	1	1		1		*		*	1	*	1	1				7
Recognition PPM	The client learns to recognize PPM through therapy			*					1	1		1			*	1		4
Learning empathy	The client learns empathy for themselves and others					1							1			1		3
Reality testing	The client learns to test the reality of PPM beliefs	1		1		*	1			1	1		1	1	*		1	8
Repetition of ST topics	The client experiences repetition in therapy topics			1	1		1					*						3
ST as confronting	The client finds schema therapy confronting and challenging									*	1	1			*		*	2
ST did not help	The client feels schema therapy did not help them				1			1										2
GST																		
Feeling better than/uninterested in others	The client feels superior to others in group schema therapy				1	1	*	1										3
Hesitance GST	The client is hesitant to engage in group schema therapy, due to reasons such as social anxiety and earlier bad experiences with group therapy	*				*		*	*		1	1	1	1	*		*	4

(Continues)

TABLE A3 | (Continued)

Code and subcode	Definition	Participant															Total
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
Insight through personification technique	The client gains insight through personification techniques in the GST													1				1
Positive experience GST	The client experienced the group therapy as positive and helpful	1	1	1		1	1	1	1	1	1	*	1	1	1	1	1	14
Recognition in/ insight through others	The client gains recognition and insight through interactions with others	1	*	1	*	1	1	1	1	1	1	*	1	1	1	1	1	13
ImRs																		
Insight into emotional needs	The client gains insight through emotional needs through ImRs		*	1		1	1	1	1	1	1	*	1	1	1	1	1	12
Scepticism ImRs	The client is sceptical about the effectiveness of ImRs							*							1			1
Insight past and present experiences	The client gains insight into past and present experiences through ImRs				1				1	1			1				*	4
Unable to do ImRs	The client is unable to participate in ImRs due to avoidance, memory issues or feeling sick							1		*				1				2
Individual therapist																		
IT guidance	The client receives guidance from their individual therapist	*							1		1			1	1		1	5
Therapist patience	The client appreciates the patience of their therapist					1			1					1				3
Unconditional acceptance IT	The client feels unconditionally accepted by their individual therapist										*		1					1
Other																		
Medication	The client reports on medication usage and its effects concerning PPM symptoms							*		1								1
PsyQ ACTP transfer problems	The client experienced problems with transferring to PsyQ ACTP			1	1			1		1								4

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TABLE A4 | Codes, coding and intercoder disagreement of Theme 4: Posttherapy experiences.

Code and subcode	Definition	Participant															Total
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
Change in PPM phenomenology																		
Increase PPM intensity	The client reports an increase in PPM intensity after ST												*	1				1
Increase PPM frequency	The client reports an increase in PPM frequency after ST								1									1
Reduction PPM credibility	The client reports a reduction in PPM credibility	*	1	1		*	1	1	*	1	1	1	1	1	1	1	1	12
Reduction PPM frequency	The client reports a reduction in PPM frequency	1	1	1	1	1	1			1	1	1	1	1	1	1	1	14
Reduction PPM intensity	The client reports a reduction in PPM intensity	*	1	1	1	1	1		1	1	1	1	1	1	1	1	1	14
Reduction voice hearing	The client reports a reduction in voice-hearing													*	*	1		1
Change in relationship PPM																		
Acceptance PPM	The client learns to accept the presence of PPM in their life		1	1									1	1			1	5
Change in perception of PPM	The client reports a change in how they perceive PPM		1	1		*	1	*	1	1	1	1	1	1	*	*	*	9
Control over PPM	The client feels they have more control over PPM influences	1	1	1		1	1	1	1	1	1	1	1	1	1	1	1	15
Disconnection from PPM	The client feels (more) disconnected from PPM	1	*	1		1		1	1	1	1	1	1	1	1	1	1	13
Change in symptoms																		
Increase moods and emotions	The client reports an increase in experienced moods and emotions								1	1		1						3
Reduction behavioural symptoms	The client reports a reduction in maladaptive (coping) behaviours					*						1	1	*	*	1		3
Reduction demanding parent	The client reports a reduction in the demanding parent mode									1			1					2
Reduction impulsiveness	The client reports a reduction in impulsive behaviours		1	1		1		1							1	1	*	6
Reduction of moods and emotions	The client reports a reduction in mood swings and emotional instability		*							1	1		*	1	*		*	3
Reduction physical symptoms	The client reports a reduction in physical symptoms associated with PPM	1	1			*	1	1	1	1	1	1	1	1	1		1	12
Self-understanding and emotional management																		
Improved emotion regulation	The client reports an improved ability to regulate emotions					*	1		1		1	1	1	*	1	1	1	8
Increased empathy	The client reports increased empathy for themselves and others												1					1
Reduced harshness towards self	The client reports being less harsh and critical towards themselves	*	*			*	*	*			1		1	*	*		*	2
Increased self-awareness	The client has an increased awareness of themselves and their PPM-related patterns	*	*	1		*	*	*	1	1	1	1	1	1	*	1	1	9

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TABLE A5 | Codes, coding and intercoder disagreement of Theme 5: Current triggers and coping.

Code and subcode	Definition	Participant																Total
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
Adaptive coping																		
Adaptive decision-making	The client makes decisions more adaptively post-ST	*	*	1		1	1	1		1	1	1	1	1	1	1	*	11
Adaptive self-soothing	The client uses adaptive self-soothing techniques	1	*	1		1		*	1		1	1	1	1	1	1	*	10
Boundaries	The client establishes and maintains healthy boundaries			1		1					1			1	*			4
Ignoring PPM	The client learns to ignore PPM influences								1	1					*			2
Interfering PPM	The client actively interferes with PPM processes	*	1	*		1		*	1		1	1	1	*	1	1	1	9
Feedback ST																		
Other feedback ST	The client provides feedback on specific schema therapy elements	*		*	1				*	*	*	1		*	*	*		2
Mistrust MHCP	The client experiences mistrust towards mental health care providers				1			1										2
Wanting more therapy	The client expresses a desire for more therapy		*			1	1			1							*	3
Future goals																		
Improving healthy adult	The client aims to further develop their healthy adult mode						1											1
Letting go of control	The client works on letting go of the need for control								1						*			1
Letting go of PPM	The client aims to release the attachment to PPM									1			1					2
Post therapy self-image																		
Development of robust sense of self	The client reports a stronger sense of self																	
Improved self-image	The client experiences an improved self-image	1	1	1		1	1		1	1	1	1	1	1	1	1	1	14
Self-acceptance and	The client feels more self-acceptance and self-worth	1	1	1		1					1		1	*	1		1	8
Supportive factors																		
Social support/ feedback	The client receives social support and feedback		1	1		1	1	1	1	1	1	1	1	1	1		1	13
Recognition past and	The client recognizes and learns from past and present experiences	1	1	1		1	1	1	1	*	1	1	1	1	1	1	1	14
Triggers																		
Boundary violation	The client identifies boundary violations as a trigger								1								*	1
Emotional needs not met	The client identifies unmet emotional needs as a trigger									1	*			*				1
Failure	The client identifies failure as a trigger		*			1	1	1		*	1		1	1				6
Family	The client identifies family interactions as a trigger											1		*			*	1
Loneliness	The client identifies loneliness as a trigger			1		1				1							*	3

(Continues)

TABLE A5 | (Continued)

Code and subcode	Definition	Participant																Total
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
Situation/mood	The client identifies situational or mood-dependent triggers				1	*				1	1	*		*	1		1	5
Social/relationship(s) trigger	The client identifies social interactions as a trigger					*	1	1	1	1	1	1	1			1	1	9
Substance usage abuse	The client identifies substance usage as a trigger														*	1		1
Using ST tools																		
ECT as a coping tool	The client uses ECT as a coping mechanism		*	1			1					*	1					3
Taking care of the inner child	The client uses the inner child as coping technique			1		*	1				1		1	1	1			6

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