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Cognitive Therapy of Personality Disorders:
Twenty Years of Progress

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Twenty years ago, personality disorders were barely mentioned by behavior therapists or cognitive behavior therapists. The term “Personality Disorder” seemed to imply that the individual had a broken personality and that this was the root of their problems. The idea that an individual’s problems might be due to a disordered personality was not compatible with behavioral and cognitive behavioral conceptualizations and many behaviorists were inclined to think of “personality disorders” as a psychoanalytic construct that either did not exist or was of little relevance.

However, significant changes in the conceptualization and treatment of personality disorders have occurred since then. First, personality disorders have been more clearly and more behaviorally defined as “an enduring pattern of experience and behavior ... that is pervasive and inflexible ... and leads to distress or impairment” (APA, 1980). Thus it is no longer necessary to understand personality disorders as resulting from a broken personality. Second, it has been found that about 50% of clients in many outpatient settings meet diagnostic criteria for at least one personality disorder diagnosis (Turkat & Maisto, 1985). Third, some outcome studies found that CBT was much less effective with clients diagnosed with personality disorders than with clients in general. These findings were sobering to cognitive behavior therapists. Some suggested that CBT could not be used with personality disorders (Rush & Shaw, 1983). Others started to

develop CBT approaches tailored to clients diagnosed with personality disorders (for example, Fleming, 1982; Pretzer, 1982; Simon, 1982; Young, 1982).

The Evolution of Cognitive Conceptualizations of Personality Disorder

Therapists often find that some of their clients do not respond well to standard treatment. They may idealize their therapist, display outright hostility, overwhelm their therapist with recurrent crises, demand special treatment, or make extraordinary efforts to please. A high proportion of these individuals are found to have an Axis II disorder in addition to the Axis I problem for which they originally sought treatment.

How are therapists to understand Personality Disorders in cognitive-behavioral terms? The first attempts were fairly straightforward. Theorists suggested that personality disorder clients were complex and difficult to treat simply because these individuals had many concurrent problems (Stephens & Parks, 1981). Perhaps all the clinician needs to do is to match treatments to symptoms. For example, Table 1 lists the symptoms of Dependent Personality Disorder and some interventions that could be used if one simply matched treatments to symptoms. This approach had the virtue of being simple and straightforward and did not require any changes in theory or therapy. Unfortunately, symptomatic treatment for individuals with Axis II disorders often is not very effective (for example, see Giles, Young, & Young, 1985).

Table 1 about here

The second stage of the evolution of cognitive-behavioral approaches to personality disorders came with the realization that individuals with personality disorders not only had many problems, but also that most of these problems occurred in an interpersonal context. Thinking of personality disorders as disorders of social behavior provided an organizing principle which permitted a more strategic approach to intervention (see Turkat & Maisto, 1985). Rather than approaching the many problems encountered by an individual with dependent personality disorder haphazardly, one can think strategically: "What is disrupting the individual's interpersonal interactions and what can we do about it?" Table 2 illustrates the intervention approach which follows from this view of personality disorders.

Table 2 about here

Up to this point, cognitive-behavioral investigators had approached personality disorders from a largely behavioral perspective. However, behavioral perspectives had some difficulty accounting for persistent, cross-situational consistencies in behavior since most of their theoretical concepts were situation-specific. More cognitively-oriented approaches (such as Beck, Rush, Shaw, & Emery, 1979) had a major advantage in explaining cross-situational consistencies in behavior since they emphasized the central role of the individual's core beliefs and assumptions. Some cognitive concepts, such as

automatic thoughts were situation-specific, but others, such as core beliefs or schemas¹, were not.

The individual's core beliefs and assumptions, along with automatic thoughts and images, were hypothesized to be the cognitive content of mental structures, termed schemas, which shaped information processing and thereby had an important influence on emotion and behavior. In theory, once a schema was acquired, it persisted. The schema was inactive when it was not relevant to the immediate situation and it automatically became active when a relevant situation was encountered. Since a dysfunctional schema would have a major impact in any relevant situation this helped explain the pervasive, persistent problems that occurred in a wide range of situations. This view had clear implications for treatment (see Table 3). If the symptoms of personality disorders were the result of dysfunctional schemas, then treatment should focus specifically on modifying the dysfunctional cognitions contained in the schemas.

Table 3 about here

¹ In works on Cognitive Therapy the terms "schema", "core belief", "underlying assumption", "dysfunctional belief", etc. have sometimes been used interchangeably and at other times, distinctions have been drawn between these closely related terms. In contemporary usage, *schemas* are cognitive structures which serve as a basis for screening, categorizing, and interpreting experiences. *Core beliefs* are unconditional beliefs such as, "I'm no good." "Others can't be trusted." "Effort does not pay off." These often operate outside of the individual's awareness and often are not clearly verbalized. *Underlying Assumptions* or *Dysfunctional Beliefs* are conditional beliefs which shape one's response to experiences and situations. For example, "If someone gets close to me, they will discover the 'real me' and reject me." These may operate outside of the individual's awareness and may not be clearly verbalized or the individual may be aware of these beliefs.

The idea that personality disorders were a product of dysfunctional schemas had considerable appeal. However, this view did little to explain why personality disorders are much more difficult to treat than Axis I disorders. After all, clients with Axis I problems often had dysfunctional schemas that played a role in their problems and Cognitive Therapy routinely included time spent identifying and modifying them (J. Beck, 1995). What accounted for the difference in treatment difficulty?

Young (1990; Young & Lindemann, 1992) hypothesized that, rather than having ordinary maladaptive schemas, individuals with personality disorders had what he termed “Early Maladaptive Schemas” (EMSs) that differed in important ways from the maladaptive schemas of Axis I clients. He hypothesized that Axis II clients actively avoided activation of EMSs and used Schema Coping Mechanisms (SCMs) which made it difficult for therapists to modify EMSs. See Young, Weishaar, and Klosko (2003) for a discussion of EMSs, SCMs, and a variety of intervention approaches designed to address these new concepts.

While this modification of Cognitive Therapy was a plausible approach to understanding and treating personality disorders, it had the disadvantage of adding considerable complexity. Another approach to the conceptualization and treatment of personality disorders combined the idea that personality disorders are disorders of interpersonal behavior with the idea that personality disorders result from dysfunctional schemas (see Safran & McMain, 1992). This provided a basis for understanding and treating personality disorders without adding to the complexity of Cognitive Therapy.

In this view, as in the schema-focused approaches, dysfunctional schemas are seen as having a broad impact on cognition, emotion, and behavior. However, it also

suggests that others' responses to the individual's interpersonal behavior can result in experiences which either reinforce or challenge dysfunctional beliefs and assumptions. If an individual's interpersonal behavior consistently elicits responses from others which reinforce dysfunctional beliefs and assumptions, this can result in self-perpetuating cognitive-interpersonal cycles which are quite resistant to change. Pretzer and Beck (1996) theorized that, when this type of self-perpetuating cycle produces pervasive problems, this results in the cross-situational consistencies in behavior which are labeled "personality disorders"

The view of personality disorders as the product of self-perpetuating cognitive-interpersonal cycles has important implications for intervention (see Table 4). If dysfunctional schemas play a central role in personality disorders one goal of intervention will be to modify the dysfunctional beliefs at some point. However, if self-perpetuating cycles continually reinforce dysfunctional beliefs, the therapist may need to moderate the self-perpetuating cycles and try to shift the individual to more adaptive interpersonal behavior before addressing the dysfunctional beliefs or the therapist may need to address the dysfunctional beliefs and the dysfunctional interpersonal behavior simultaneously.

Table 4 about here

Modifying "Standard" Cognitive Therapy for Personality Disorders

A number of authors have questioned whether Cognitive Therapy is a suitable approach for treating individuals with personality disorders (Rothstein & Vallis, 1991; Young, 1990). Vallis, Howes, and Standage (2000) examined this question empirically

by analyzing the relationship between a composite measure of personality dysfunction and scores on a measure designed to assess the extent to which respondents are suitable for short-term Cognitive Therapy. They found that high scores on the measure of personality dysfunction were associated with low scores on the measure of suitability for short-term Cognitive Therapy. While this finding might seem to support the idea that Cognitive Therapy is not suitable for individuals with personality disorders it is important to note that the results were strongest for a subscale which assesses suitability for short-term therapy in general. Vallis and his colleagues (Vallis, et al., 2000) concluded that the basic Cognitive Therapy approach needs to be modified to take the characteristics of individuals with personality disorders into account, not that Cognitive Therapy is unsuitable as a treatment for individuals with personality disorders.

A number of authors have proposed ways of modifying Cognitive Therapy for use with individuals diagnosed with personality disorders (for example, Beck, et al., 1990; J. Beck, 1998; Freeman, et al, 1990; Pretzer & Beck, 1996). Cognitive Therapy for personality disorders has much in common with Cognitive Therapy for depression (Beck, et al., 1979). Both emphasize the development of a cognitive conceptualization, a collaborative therapeutic relationship, a relatively structured therapy session, a problem-solving approach, active evaluation of clients' cognitions, psychoeducation, and actively helping clients to learn new skills and apply them in problem situations (J. Beck, 1997). However, clients with personality disorders typically have ingrained interaction patterns and dysfunctional cognitions that complicate many aspects of therapy (see Table 5). Therapists must make some adjustments in order to apply the principles of Cognitive

Therapy effectively with clients who have personality disorders (J. Beck, 1997) as described below.

Table 5 about here

Principle 1: Cognitive Therapy is based on a cognitive formulation. Therapists working with clients with either Axis I or Axis II diagnoses focus on specific situations in which the client's problems are manifested and make a cross-sectional analysis of the client's thoughts, feelings, and actions in problem situations. This information provides a basis for developing an understanding of the ways in which the client's cognitions, emotions, and behavior interact and contribute to the client's problems. This cognitive conceptualization (see Figure 1 for an example) provides a basis for planning treatment to be as effective and efficient as possible. The process of data collection with clients who have personality disorders can be problematic. These individuals often hold beliefs that interfere with a free and candid disclosure of their thoughts, feelings, and actions (see Table 5). The conceptualization that eventually emerges as therapist and client develop an understanding of the client's problems is often much more complex than is the case with most Axis I problems.

Figure 1 about here

Principle 2: Cognitive Therapy emphasizes a strong therapeutic alliance.
Cognitive therapy is based on a collaborative relationship in which therapist and client

work together towards goals the client values. They jointly decide which issues to address and how to go about doing so. The therapist talks explicitly with the client about the goals of therapy and works with them to obtain symptomatic relief and to help the client acquire useful skills. With straightforward Axis I clients, a strong collaborative relationship is usually easy to establish. However, for clients with Axis II problems the therapeutic relationship itself often becomes a focus of therapy. The client's dysfunctional beliefs about themselves, about the therapist, and about relationships often become activated during sessions.

During therapy sessions, it is important for the therapist to be alert for verbal and non-verbal cues of a shift in the client's mood and then to assess the client's thoughts and feelings on the spot. While the complexity of establishing and maintaining a strong therapeutic alliance complicates therapy with clients who have personality disorders, the time spent doing so is necessary as a foundation for effective intervention and provides insight into dysfunctional beliefs and interpersonal strategies that affect the client's other relationships in much the same way as they affect therapy.

Principle 3: Goal-setting and problem-solving are integral parts of cognitive therapy. From the beginning of Cognitive Therapy, the therapist helps the client identify overall goals for therapy and interim steps towards those goals. Axis I clients usually do not have much trouble doing so but many Axis II clients have difficulty specifying goals and working to achieve them. They may express vague or unrealistic goals, specify goals in terms of what they want someone else to do rather than identifying changes they want to make, or their goals may change from week to week. Also, while many Axis I clients have reasonably good problem-solving skills, clients with personality disorders often do

not know how to solve problems effectively or they may engage in dysfunctional problem-solving strategies. With an Axis II client, the therapist may need to spend extra time identifying consistent achievable goals and helping the client learn effective problem-solving strategies.

Principle 4: Cognitive Therapy emphasizes structured sessions. Therapy proceeds most efficiently when the therapist actively structures the session so that the time is used productively (see Table 6). However, many Axis II clients hold beliefs that make it hard for them to tolerate a structured approach to therapy (see Table 5). Therapists should not unilaterally impose a structured approach on clients who resist it. The therapist must judge whether efforts to identify and address these beliefs when they first emerge are likely to be productive or whether to vary the structure of the session initially and wait until the therapeutic alliance is stronger before addressing these cognitions. Some Axis II clients, particularly those who are quite isolated, may benefit from being able to talk without interruption for the initial portion of the session. It may be useful to allow time for this at the beginning of the session and then implement the more standard structure for the remainder of the session.

Table 6 about here

Principle 5: Cognitive Therapy emphasizes cognitive restructuring. An important part of therapy involves identifying, evaluating, and responding to the client's dysfunctional thoughts and beliefs. The therapist helps the client learn that it is not the situation per se which shapes one's reactions but one's interpretations of the situation.

Axis II clients may find this concept hard to grasp, may avoid facing upsetting thoughts and feelings, or may feel invalidated by the therapist's attempts to help them look at their experiences from a different point of view. This complicates the process of cognitive restructuring.

Principle 6: Cognitive Therapy addresses client's developmental histories and uses specialized techniques to alter core beliefs, as needed. Most Axis I clients are able to modify their dysfunctional thoughts and core beliefs without examination of childhood events and doing so may take time away from solving here-and-now problems. Therefore, Cognitive Therapy with clients who have Axis I problems often involves spending very little time on childhood experiences. Clients with personality disorders, in contrast, often have extremely rigid beliefs stemming from childhood experiences. It often can be quite useful for the therapist to help the Axis II client understand how his or her beliefs developed naturally from early experiences and were reinforced by other experiences over time. The same techniques are used in modifying dysfunctional beliefs with Axis II clients as with Axis I clients (see J. Beck, 1995) but Axis II clients may need additional help in developing more positive, reality-based beliefs to replace their dysfunctional beliefs.

Principle 7: Cognitive therapy incorporates relapse prevention techniques. Cognitive therapists are concerned not only with helping clients overcome their problems but also with teaching them how to deal with problems on their own. In therapy they learn how to solve problems, restructure their thinking, and change their behavior in order to overcome problems as they arise. This learning improves the likelihood that gains achieved through therapy will persist after the conclusion of treatment.

Relapse prevention also typically involves responding to clients' fears about ending therapy, introducing the idea that active steps are needed to maintain the gains made in therapy, anticipating high-risk situations that the client may encounter and planning how to cope with them, and identifying early warning signs that a problem is returning and identifying strategies for forestalling relapse. While this is important for all clients, it is crucially important for Axis II clients. Often, negative core beliefs are modified but not completely eliminated. There is a risk that future events could reactivate dysfunctional beliefs and maladaptive behaviors. It is important for the client to recognize this and for them to be prepared to deal effectively with this if it occurs.

Some Axis II clients express a desire terminate therapy prematurely, perhaps because the therapeutic relationship has broken down, because their Axis I symptoms have remitted and they do not want to engage in the hard work of modifying their core beliefs and compensatory strategies, or because they are testing how their therapist will respond. Other Axis II clients cling to therapy even though they have achieved significant improvement and seem equipped to face life without on-going therapy. When the number of sessions is not constrained by forces beyond the client's control (e.g. insurance), it is important for the termination of therapy to be a decision that therapist and client reach collaboratively. It is important for the therapist to take an active role in assessing the extent to which the client's goals for therapy have been accomplished and the degree to which the client has mastered the skills needed to maintain his or her gains. In either case, it can be important for the therapist to help the client explore the pros and cons of terminating therapy versus continuing in therapy and to address any unrealistic hopes or fears. When a client seems ready to terminate therapy but is reluctant to do so,

it may be useful to schedule appointments at longer intervals so that the client has a greater opportunity to discover whether they can deal with problems as they arise.

Applying a Cognitive/Interpersonal Perspective to Understanding and Treating Personality Disorders

An example of how this approach can be applied to understanding one particular personality disorder (in this case, Borderline Personality Disorder) is shown graphically in Figure 1. Three beliefs that are central in Borderline Personality Disorder are seen on the left side of this Figure. They are: “The world is dangerous and malevolent,” “I am weak and vulnerable,” and “My feelings are unacceptable and dangerous.” These beliefs have important effects on cognition and behavior.

Figure 1 about here

Individuals who see the world as a dangerous place and themselves as vulnerable, have specific fears in many different situations. They often become hypervigilant for signs of danger and overlook or discount signs of safety. This bias in information processing generally occurs outside of the individual’s awareness (until therapy) and strengthens their conviction that the world is a dangerous place.

One strategy for remaining safe in a dangerous world is to be vigilant, on guard, and ready to defend oneself. Individuals who are hypervigilant for signs of danger and who rely on this interpersonal strategy may well develop Paranoid Personality Disorder.

However, individuals with Borderline Personality Disorder have a second core belief. They typically see themselves as weak and vulnerable, as not being competent to handle the dangers which they see around them. This belief blocks them from relying on their own capabilities.

Individuals who see themselves as weak and vulnerable and incompetent have a low sense of self-efficacy and are likely to avoid situations that they fear. This avoidance, in turn, reinforces the belief that they cannot cope with the feared situation. When individuals see themselves as being weak and vulnerable in a dangerous world, one solution is to find someone capable to rely on. Individuals who consistently rely on others and subjugate themselves to assure that others will not withdraw their help may develop Dependent Personality Disorder.

Unfortunately, individuals with Borderline Personality Disorder hold a third belief, "My feelings are unacceptable and dangerous" which blocks this solution. Because they see themselves as inadequate and weak, the idea of finding someone strong and capable to take care of them is appealing. However, because they see themselves as inherently unacceptable, relying on a protector seems unacceptably risky. They anticipate that they will be rejected and abandoned once their protector really gets to know them. As a result, they have strongly conflicting feelings about depending on someone else.

In addition, since individuals with borderline personality disorder see their emotions as dangerous and unacceptable to others, they often engage in extreme attempts to avoid, control, or escape from strong emotions. They suppress, avoid, or deny emotions but then suddenly manifest them at full intensity. This results in recurrent

problems in relationships that reinforce the belief that these emotions are unacceptable and dangerous and that encourage further attempts to avoid, control, or escape emotions

Because clients with borderline personality disorder have a proclivity towards intense emotional reactions, have conflicting feelings about depending on others, and have a low frustration tolerance, their relationships tend to be intense and unstable. They anticipate that others will not understand and respect their feelings if they speak up directly. Therefore, they are likely to engage in manipulative behavior rather than expressing themselves directly and assertively. All of these factors contribute to persistent problems in relationships and contribute to feelings of depression, hopelessness and suicidality.

In addition, individuals with Borderline Personality Disorder tend to engage in dichotomous thinking. This dichotomous thinking adds to the intensity of the emotional reactions, the interpersonal interactions, and the conclusions they draw in the situations discussed above.

This conceptualization of Borderline Personality Disorder has clear implications for intervention (see Table 7). Clients with Borderline Personality Disorder usually enter therapy at a time of crisis and therapy usually needs to start by working on dealing with these crises. As the therapist does so, the problems that Linehan (1993) terms “therapy interfering behaviors” are likely to arise. Clients with Borderline Personality Disorder typically are ambivalent about relying on others, anticipate rejection, and tend towards intense, unstable relationships. Behaviors ranging from noncompliance, to intense emotional reactions during the session, to suicidality and self-mutilation must be addressed promptly so that they do not disrupt therapy. Once these hurdles have been

cleared, the therapist is in a position to work to increase the client's ability to cope with intense emotion, to help the client to shift to more adaptive interpersonal behavior, and eventually to modify the client's dysfunctional beliefs. Finally, therapy will end by working explicitly on relapse prevention

Table 7 about here

This treatment approach makes use of many of the interventions commonly used in Cognitive Therapy, such as using Thought Records to identify dysfunctional thoughts and working to modify core beliefs (see J. Beck, 1995). However, it is also important to address issues that may not be a focus of therapy with the average client such as increasing affect tolerance and working on skills for coping with intense emotions (Farrell & Shaw, 1994). Therapists also need to pay more than the usual amount of attention to the therapeutic relationship and their own emotional responses. They may need to use cognitive therapy skills themselves to maintain empathy and commitment while working with clients whose dysfunctional behaviors and extreme emotionality can be quite challenging.

Please note that the discussion above applies specifically to Borderline Personality Disorder. Each of the personality disorders is conceptualized differently and intervention strategies vary among the personality disorders. A discussion of each of the personality disorders is beyond the scope of this chapter. Interested readers can find discussions of each of the personality disorders in Freeman, et al. (1990) and in Beck, et al. (2003).

The Empirical Status of Cognitive Therapy as a Treatment for Personality Disorders

One of the strengths of Cognitive Therapy is the extensive body of research supporting both the theory and the therapy. The research base for Cognitive Therapy with personality disorders is much smaller than is the case with many Axis I disorders and, in the past, some expressed concern that the rapid expansion of theory and practice has outstripped the empirical research (Dobson & Pusch, 1993). Fortunately, a growing body of research supports Cognitive Therapy as an approach to understanding and treating personality disorders. A detailed review of empirical findings regarding Cognitive Therapy of personality disorders is beyond the scope of this chapter. Readers who wish a more comprehensive review should see Pretzer (1998) or Beck, et al. (2003).

Research has produced a number of findings relevant to the cognitive understanding of personality disorders. For example, individuals diagnosed with personality disorders show elevated levels of dysfunctional attitudes (O'Leary, et al., 1991, Illard & Craighead, 1999), the endorsement of personality-disorder-relevant beliefs predicts the level of personality disorder traits (Arntz, 1999; Bell & Cecero, 2001), and individuals with specific personality disorders endorse the particular beliefs hypothesized to play a role in those disorders (Arntz, Dietzel & Dreessen, 1999; Beck, Butler, Brown, Dahlsgaard, Newman & Beck, 2001). Looking specifically at borderline personality disorder, Arntz and his colleagues found an elevated level of dichotomous thinking (Veen & Arntz, 1999), as predicted, and found that dysfunctional beliefs mediate the relationship between traumatic experiences and borderline symptomatology (Arntz, et al., 1999).

Table 8 provides an overview of the available research on the effectiveness of Cognitive Therapy as a treatment for individuals with personality disorders. Many clinical reports assert that Cognitive Therapy can provide effective treatment for these individuals but there are fewer well-controlled outcome studies. Fortunately, the studies that are available provide findings that are quite encouraging. Single-case design studies have shown that individualized cognitive-behavioral treatment was effective for some clients with personality disorders but that treatment was partially effective or ineffective for others (Turkat & Maisto, 1985, Nelson-Gray, Johnson, Foyle, Daniel, & Harmon, 1996). Studies of the effects of comorbid Axis II disorders on the outcome of cognitive-behavioral treatment for Axis I disorders have produced a complex pattern of results: sometimes the presence of an Axis II disorder decreases the effectiveness of treatment, sometimes it has no negative impact, and sometimes treatment for an Axis I disorder produces improvement in the Axis II disorder as well (see Pretzer, 1998 or Beck, et al., in press).

Table 8 about here

Controlled outcome studies of cognitive-behavioral treatment approaches have only been conducted for three personality disorders, antisocial (Woody, McLellan, Luborsky, & O'Brien, 1985), avoidant (Stravynski, Marks, & Yule, 1982, Greenberg & Stravynski, 1985), and borderline personality disorders. Woody, et al. (1985) found that subjects with Antisocial Personality Disorder and a comorbid Major Depression responded well both to Cognitive Therapy and to Supportive-Expressive Therapy.

Subjects showed significant improvement on 11 of 22 outcome variables including decreases in objective measures of antisocial behavior such as drug use and legal activity. However, antisocial subjects who were not depressed did not respond to either treatment, apparently due to a lack of motivation for change.

Subjects with Avoidant Personality Disorder were found to respond both to social skills training and to social skills training combined with cognitive interventions (Stravinsky, et al., 1982) showing significant decreases in social anxiety and avoidance and improvement in interpersonal relationships. This finding was initially interpreted as showing that cognitive interventions added little to treatment, even though the two treatment approaches were equally effective. However, in a subsequent study, Greenberg and Stravynski (1985) observed that the client's fear of ridicule contributed to premature termination in many cases and suggested that interventions that modify clients' cognitions could add substantially to the effectiveness of treatment.

Research in using Dialectical Behavior Therapy (DBT) for the treatment of Borderline Personality Disorder (Linehan, Armstrong, Suarez, Allmon, & Heard, 1991; Linehan, Tuteck, & Heard, 1992; Linehan, Heard & Armstrong, 1993) has provided evidence that cognitive-behavioral interventions can be effective with clients who have severe personality disorders. One year of cognitive-behavioral intervention produced significant improvement in clients who met diagnostic criteria for Borderline Personality Disorder and also had histories of multiple psychiatric hospitalizations, were chronically parasuicidal, and were unable to maintain employment. Subjects who received DBT showed significant decreases in suicide attempts, self-mutilation, and re-hospitalization but continued to show elevated levels of depression, anxiety, and interpersonal problems.

The investigators concluded that more than one year of treatment was needed to obtain maximum benefits from DBT.

Controlled outcome research is sometimes criticized as not reflecting the realities of clinical practice. Evidence regarding the effectiveness of Cognitive Therapy as a treatment for personality disorders in clinical practice is provided by a study of the effectiveness of Cognitive Therapy for depression in a real-life private practice setting conducted by Persons, Burns, and Perloff (1988). When the investigators examined the impact of personality disorders on treatment outcome, they found that clients with personality disorders were at higher risk of dropping out of treatment prematurely. However, when they were able to retain the Axis II clients in therapy the eventual improvement in depression scores was similar for clients with personality disorders as for clients without a personality disorder diagnosis.

Obviously, much more research is needed to test cognitive-behavioral conceptualizations of personality disorders and to test the effectiveness of contemporary approaches to Cognitive Therapy for each personality disorder. The quality of this research can be improved in several ways. First, a number of studies have used DSM's three clusters of personality disorders as the unit of analysis rather than looking at personality disorders individually. However, cognitive approaches conceptualize each personality disorder differently and propose somewhat different treatment approaches for each of the personality disorders. While it can be difficult to obtain an adequate sample size with some of the less common personality disorders, combining disparate disorders into clusters for research purposes is not useful unless there is a clear theoretical rationale for doing so. Second, much of the existing cognitive-behavioral research relies on simple

self-report measures of dysfunctional beliefs. Use of this methodology assumes that individuals can reliably rate the strength of their dysfunctional beliefs or schemas. Yet, according to cognitive theory, dysfunctional schemas often operate outside of awareness and in clinical practice it often takes significant time and effort to identify clients' dysfunctional beliefs. Clear evidence is needed that these measures actually assess dysfunctional beliefs, not more superficial attitudes. Alternative methods for assessing dysfunctional beliefs and other relevant cognitions are available and should be used more widely. These include Thought Sampling or Experience Sampling methodology (Hurlburt, Leach, & Saltman, 1984), laboratory tasks which provide a more direct method for assessing schemas (for example, McNally, Riemann & Kim, 1990), and content analysis of responses to schema-relevant stimuli.

The past two decades have seen rapid advances in theory, practice, and empirical research into the application of Cognitive Therapy to the treatment of personality disorders. While there are grounds for legitimate concern that there is a risk that clinical innovation will outstrip the empirical research (Dobson & Pusch, 1993), a growing body of research supports Cognitive Therapy as an approach to understanding and treating personality disorders. Given the complexity of clients with personality disorders and the difficulties encountered in therapy with these individuals, it is encouraging that the past two decades have seen the evolution of more effective approaches to understanding and treating personality disorders. As research and innovation continue, we should see continued advances in theory and practice.

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Table 1

Intervention Approach Suggested by Thinking of Personality Disorders as a Collection of Symptoms

Symptom	Intervention
Difficulty making decisions	Improve decision-making skills
Avoids responsibility	Desensitization to responsibility
Difficulty disagreeing with others	Assertion training
Difficulty initiating projects	Desensitization, improve skills
Excessive reassurance-seeking	“Weaning”
Discomfort with being alone	Desensitization
Urgently seeks new relationship	Desensitization to being alone
Fear of self-reliance	Desensitization, improve skills

Table 2

Intervention Approach Suggested by Thinking of Personality Disorders as Disorders of Interpersonal Behavior

Conceptualization	Interventions
Lack of confidence in own capabilities produces excessive reliance on others, under-use of own skills, and fear of abandonment	First increase sense of self-efficacy and improve skills then gradually increase reliance on own skills and decrease reliance on others
Fear of abandonment inhibits assertion and produces excessive compliance	As confidence in own capabilities increases, increase assertion. Use assertion training if necessary

Table 3

Intervention Approach Suggested by Thinking of Personality Disorders as a Product of
Dysfunctional Schemas

Conceptualization	Intervention
Symptoms are due to dysfunctional schemas	Treatment should focus on identifying and modifying dysfunctional schemas

Table 4

Intervention Approach Suggested by Thinking of Personality Disorders as a Product of
Cognitive/Interpersonal Cycles

Conceptualization	Intervention
Dysfunctional schemas bias cognition, emotion, and behavior in a way that reinforces dysfunctional beliefs	Base interventions on an individualized understanding of the cognitive/interpersonal cycles
The client's interpersonal behavior elicits responses from others which reinforce dysfunctional beliefs	Initially work to moderate the intensity of the self-perpetuating cycles then work to change interpersonal behavior. Work to modify the dysfunctional beliefs after the self-perpetuating cycles have been attenuated.

Table 5

Cognitions That Can Complicate the Treatment of Clients with Personality Disorders

Stage of Treatment	Examples of Problematic Cognitions
Initial Evaluation, Developing a Conceptualization	<p>“If I reveal myself, I’ll be rejected.”</p> <p>“If people know about me, they’ll be able to hurt me.”</p>
Developing and Maintaining a Therapeutic Alliance	<p>“If I trust others, I’ll be hurt.”</p> <p>“I have to rely on others to solve my problems.”</p>
Structuring the Therapy Session	<p>“People must know every detail or they won’t give me the ‘right’ help.”</p> <p>“If others interrupt me, it means they don’t care.”</p> <p>“If I let others direct me, it means they are controlling me.”</p>
Setting Goals	<p>“If I try to [work towards a goal], I’ll fail.”</p> <p>““If I can’t accomplish something totally, it isn’t worth working towards at all.”</p> <p>“If I accomplish my goals, things will get worse.”</p>
Problem-Solving	<p>“My problems can’t be solved.”</p> <p>“Others should solve my problems for me.”</p> <p>“It is unfair that I have to deal with these problems.”</p>

<p>Eliciting and Responding to Automatic Thoughts</p>	<p>“If I think about upsetting things, I won’t be able to tolerate the feelings.”</p> <p>“If someone questions the validity of my thoughts, he or she is invalidating me.”</p>
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Table 5 Continued

<p>Skills Training</p>	<p>“If I’m assertive with others, they’ll get angry and reject me.”</p> <p>“If I try my new skills, I’ll fail.”</p> <p>“If I become more competent, I’ll be abandoned.”</p>
<p>Homework</p>	<p>“If I do what others tell me to, it shows that I am weak.”</p> <p>“If I accomplish this step, others will just expect more and more of me.”</p> <p>“If I don’t feel motivated, I can’t do it.”</p>
<p>Modifying Dysfunctional Beliefs</p>	<p>“If my belief isn’t true, I don’t know who I am.”</p> <p>“If I admit that my belief isn’t true, it shows that I am weak.”</p>

Termination and Relapse Prevention	“If my therapist wants me to terminate, it means he or she doesn’t care about me.” “If I end therapy, I’ll fall apart.” “If I try to solve problems on my own I’ll fail.”
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Table 6

Structure of a Typical Cognitive Therapy Session

Mood Check	Therapist briefly assesses client's mood.
Agenda Setting	Therapist finds out what problems the client wants to address and proposes any additional issues he or she wants to address as well.
Bridge from Previous Session	Therapist finds out about major events since previous session, assesses client's overall level of functioning, reviews what the client learned from the previous session, and reviews the client's homework.
The Body of the Session	Therapist and client address the items on the agenda in order of priority collecting detailed information, utilizing a problem-solving approach, and teaching new skills.
Developing Homework	Therapist and client jointly identify ways for the client to apply what he or she has learned to everyday life.
Closing	Therapist summarizes the main points covered in the session (or has the client do so) and asks for feedback about the session.

Table 7

Proposed Intervention Strategy for Borderline Personality Disorder

Establish a collaborative relationship

Improve day-to-day coping and increase self-efficacy

Decrease “therapy-interfering behaviors”

Increase ability to tolerate and modulate emotion (this includes identifying and testing
automatic thoughts)

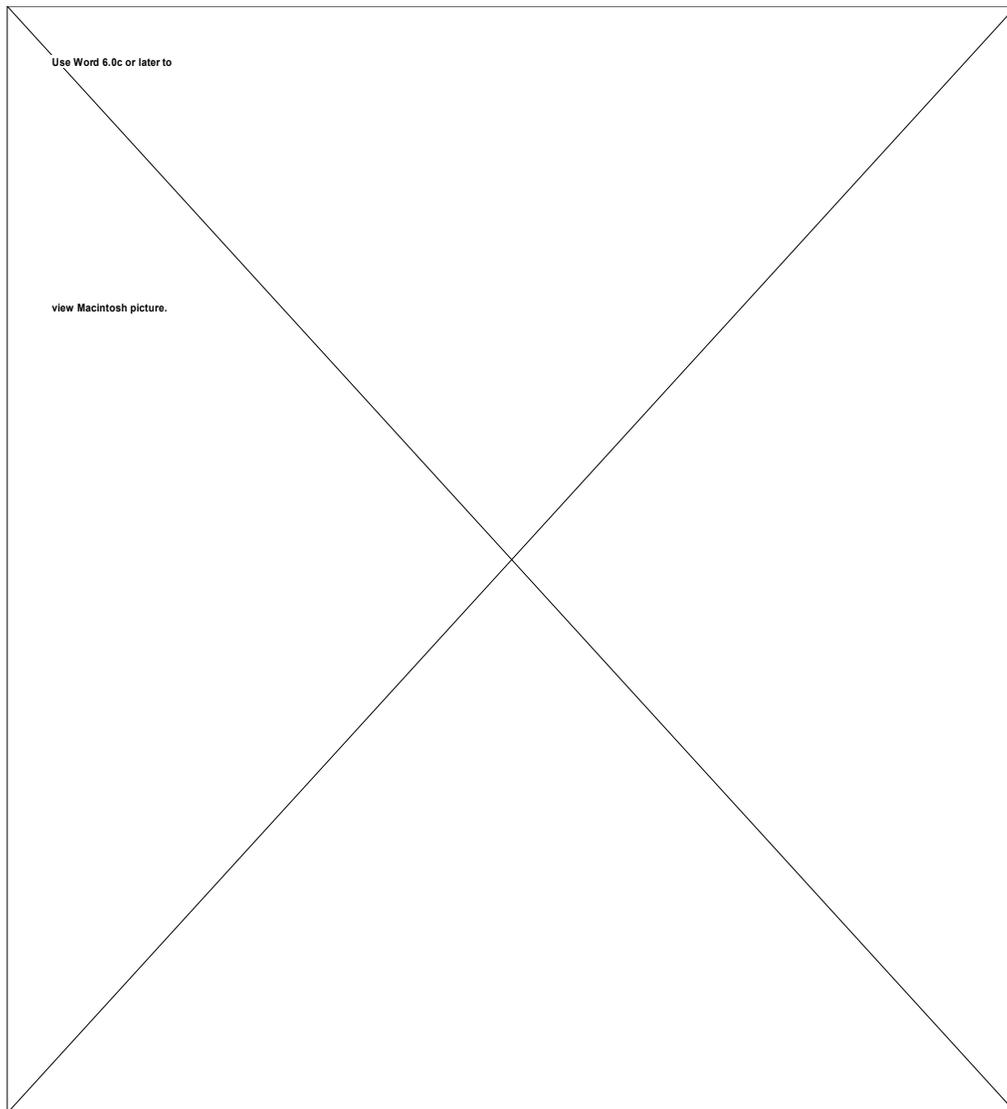
Shift to more adaptive interpersonal behavior

Modify underlying assumptions

Work on relapse prevention and prepare for termination

Table 8

The Effectiveness of Cognitive-Behavioral Treatment with Personality Disorders



- + Cognitive-behavioral interventions found to be effective.
- Cognitive-behavioral interventions found not to be effective.
- ± Mixed findings.

- ^a Cognitive-behavioral interventions were effective with antisocial personality disorder subjects only when the individual was depressed at pretest.

Figure 1

A Cognitive-Interpersonal Conceptualization of Borderline Personality Disorder

