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Cognitive-Behavioral Therapies for Personality Disorders

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Abstract: Cognitive-behavioral therapy (CBT) has been strongly identified as a time-limited treatment approach for Axis-I disorders, but CBT models for addressing personality disorders – enduring patterns of relational and emotional difficulties – are gaining greater attention. This review touches on three influential models: Beck's cognitive therapy (CT), Young's schema focused therapy (SFT), and Linehan's dialectical behavior therapy (DBT), presenting the rationale for their development, main theoretical components, and a brief discussion of their goals and means, along with a review of the growing evidence base supporting their effectiveness. The need for integrative models for treatment of this population is noted.

Cognitive-Behavioral Therapy (CBT) is primarily known as a short-term, problem-focused treatment for various disorders on Axis-I of the DSM (1), but is increasingly used for the treatment of personality disorders (PDs), more long-standing emotional, behavioral, and interpersonal problems. Nonetheless, CBT's overdue entry into the PD realm has delayed the development and evaluation of cognitive-behavioral models and treatments of PDs compared to the rich empirical developments of CBT for Axis-I disorders.

Some reasons for the delay arose from an apparent incompatibility between CBT and PDs. For one, PDs are modern-day versions of vaguely-defined "characterological pathology" posited by psychodynamic writers in the early and middle 20th century (e.g., 2). Because early CBT theory (e.g., 3) was strongly influenced by the behaviorist critique of the notion of personality "structures" or traits, it had a mistrust of hypothetical "root" personality causes, and called instead for a focus on the manifest aspects of disorders. Over time, this point was allayed by the progress made starting with DSM-III, with its genuine attempt to define PDs using more observable, often behavioral, criteria, and to base their taxonomy on sound research (cf., 4).

There is now a considerable consensus that PDs often reflect attempted adaptation to problematic early learning histories which may involve abuse, neglect, unmet needs, or simply poor fit between parental practices and child temperament. This view of PDs dictates more clinical attention to the past – i.e., to *etiology*, which has a strong *maintaining* effect. Such focus takes more time than is typically associated with brief CBT treatments, often many months or even 2–3 years, not 12–20 sessions as is the case in briefer CBT for some anxiety disorders. The tendency to keep CBT treatments present-focused and time-limited was therefore another impediment to addressing PDs.

Despite these misgivings, there are many reasons for clinicians in general and for CBT clinicians in particular to attend to PDs. First, PDs, which occur in a sizable 10–13% of the general population, have even higher prevalence rates - often exceeding 50% – in clinical settings (5). Second, the presence of a PD may complicate the course and treatment of both Axis-I disorders and non-psychiatric medical conditions. Third, PDs bring with them considerable distress and suffering for clients and loved ones, and therefore demand clinical attention. Finally, since CBT has successfully offered evidence-based interventions that reduce distress in various disorders, it was natural for cognitive-behavioral models and interventions for PDs to emerge. As this brief review of three leading CBT models (6–8) will show, the nature of PDs lends itself quite clearly and fruitfully to cognitive-behavioral conceptualizations.

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Beck's Cognitive Therapy

Beck's cognitive therapy (CT) of PDs (cf., 6) emerged from earlier work on depression (3). As with depression, a central concept here is that of *schemas*, described as cognitive structures containing an individual's basic beliefs and assumptions, which shape one's perceptions of events and responses to them (9). Schemas lie in the deepest reaches of the cognitive topography. Though they may play a part in a variety of disorders (e.g., personal responsibility schemas in OCD), short-term CBT for Axis-I disorders often proceeds with less attention to schemas than to behavior or "surface" cognitions (e.g., dysfunctional beliefs, automatic thoughts). That cannot be the case in treating PDs, where altering long-enduring patterns of affect, behavior, cognition and relationships is the goal, thus dictating attention to schemas, which play key roles in two self-perpetuating cognitive-interpersonal cycles (described below).

Schemas relevant to PDs emerge from the interaction of children's temperament with their formative environment. Temperamental vulnerabilities, which differ among the various PDs, may include biased/deficient information processing, emotion regulation, or interpersonal behavior. Theoretically, PDs (and underlying maladaptive schemas) may emerge even in individuals without temperamental vulnerability, if faced with particularly toxic family environments or harsh life circumstances; the greater the temperamental vulnerability, the less environmental contribution needed.

In Beck's model, schemas include three kinds of beliefs that play a part in one's responses to daily life. *Strategic beliefs* are assumptions about what is needed for survival or reduction of painful experiences. *Conditional beliefs* are "if…then" contingencies that dictate responses to particular triggers. *Unconditional beliefs* are chronic assumptions about the self, others and the world. For example, a person with paranoid PD may have the strategic belief "do not trust anyone," the conditional belief "if I let down my guard, I will be taken advantage of," and the unconditional belief "I am a victim; others are always out to get me."

Schemas guide information processing in ways that lead to attention, memory, and judgment biases. For example, the unconditional belief "I am a victim" will lead to a confirmation bias in attention to, and retrieval of, evidence that is consistent with this view; disconfirming evidence will be overlooked or dismissed. Even ambiguous events (e.g., someone cutting ahead in line) will trigger thoughts (e.g., "I'm being taken advantage of right now"), automatic emotional responses (e.g., anger) and emotion-congruent information processing (e.g., recall of other angering events, greater vigilance towards being "taken advantage of"). A growing number of studies (e.g., in avoidant PD, 10; in borderline PD (BPD), 11; in psychopathy, 12) document schema-driven biases. Their net effect is to maintain and perpetuate the schemas and to render them resistant to change. In Beck's (6) model, this forms the first of two self-perpetuating cycles.

A second cycle involves interpersonal behaviors that pursue characteristic automatic thoughts, and others' ensuing responses to those behaviors. For example, the schema-driven thought "I'm being taken advantage of" may lead one to behave aggressively towards the apparent perpetrator; this can lead to the other's responding in kind (e.g., escalating into conflict or violence), and thus, to the self-fulfillment of the initial schema-driven thought.

Beck and colleagues (6) developed specific versions of the cognitive model that apply to particular PDs, yet share the same overarching goal: the persistent alleviation of distress that would allow clients to lead happy and productive lives. This goal is typically achieved by (a) identifying clients' schema content in terms of strategic beliefs, conditional, and unconditional assumptions; (b) focusing on current functioning and interpersonal behavior (both in "real life" and within the therapy relationship) understood through the prism of one's schemas and the self-perpetuating cycles; and (c) recognizing the schemas' developmental origins. Therapists maintain the collaborative empiricist stand by setting agendas together with the client and suggesting behavioral experiments. However, the therapy may be initially more directive and less Socratic than in classic CT, as clients are assumed to be in greater need of guidance and to have less-developed alternative functional schemas; with time, directiveness is reduced. Throughout, less

emphasis is placed on intellectual understanding, and more on behavioral "experiments" which are more emotionally convincing. Finally, as with all CBT approaches, homework assignments are used extensively.

Though still scarce, research on CT for PDs has been promising. After two decades of mostly uncontrolled case studies (cf., 13), the last decade has brought several well-designed trials of treatment for BPD (14), avoidant (15), and obsessive-compulsive PDs (16). For example, in the first published trial of CT for BPD, Brown et al. (14) treated 32 individuals weekly for one year and reported moderate improvement in all outcome measures (including depression, hopelessness, BPD symptoms, suicidal ideation, and self-injury). In a randomized clinical trial (RCT) of avoidant PD patients (15), 63 individuals were assigned to cognitive behavioral therapy based on Beck's approach (6) or to brief dynamic therapy; both treatments consisted of 20 sessions and were manual-guided. Though both led to improvement (avoidance and anxiety as assessed by both independent raters and self-reports), the effect sizes for CBT were mostly large, and were uniformly larger, both immediately post-treatment and at six month follow-up.

An important point made theoretically (6) and empirically (16) is the centrality of the therapy relationship in effective cognitive treatment of PDs. Indeed, greater improvement was found when early therapeutic alliance and adequate repair of therapeutic ruptures (disruptions in the therapeutic process that can be used as corrective experiences) were present (16). Maintaining the patient's engagement is a challenge in treating PDs, for which dropout rates have often exceeded 50% (17). Addressing this challenge is very central to two of the most innovative CBT approaches for treating PDs – Schema Focused Therapy and Dialectical Behavior Therapy, described next.

Schema Focused Therapy

Schema Focused Therapy (SFT; 7, 18), began as an extension of Beck's model and has grown to become a unique integrative treatment for the entire spectrum of PDs (and other long-standing emotional/relational difficulties). As its name implies, SFT shares the view that schemas are central to understanding PDs. However, SFT conceptualizes schemas somewhat differently than CT: rather than purely cognitive in nature, they also encompass images, memories, bodily sensations, and emotions. SFT proposes a taxonomy of early maladaptive schemas; currently, 18 are identified, including frequently occurring ones such as emotion deprivation, defectiveness, abandonment, and subjugation. SFT holds that there exists a set of universal core emotional needs (e.g., needs for safety, security, validation, autonomy, spontaneity, and realistic limits), and that schemas emerge when these needs go unmet or are met inappropriately (e.g., excessively).

In addition to universal *needs* and to *schemas*, which are *trait*-like and pervasive in their effects, SFT devotes great attention to *modes*, the predominant emotions, schemas, or coping reactions active for an individual at a particular time. Modes are transient: at any given moment, a person is predominantly in one particular mode. There are four types of modes: child modes, maladaptive coping modes (avoidance, over-compensation, and surrender), dysfunctional internalized parental modes (e.g., punitive or critical parental voices), and a healthy adult mode (for a recent review, see 19). Most persons inhabit various modes over time; what matter are the specific identity of the activated modes and the manner of transition from one to another. Several PDs involve abrupt transition (and therefore strong dissociation) among specific modes. Indeed, the mode concept was introduced following the realization that (trait-like) schemas leave unexplained many of the more fast-changing symptoms of clients with BPD or narcissistic personality characteristics, who experience quick and often intense fluctuation among various mood states – in a sense, flipping among modes in response to external or internal triggers.

The more the client is characterized by fluctuations among various states, the more room there is for "mode work," in which therapists attune to specific modes associated with various states in "real life" and in the therapy room. In collaboration with the client, these get labeled, their origin is explored, they are linked to current problems, and the possibility of modifying or giving them up

is explored. Following such preparation, dialogues between modes are initiated (typically involving the vulnerable child and/or the healthy adult modes, in dialogue with one of the dysfunctional coping or maladaptive parental modes).

Mode work is both cognitive and experiential in nature, and is an example both of the integrative nature of SFT and of its divergence from Beck's CT. By integrating CBT with ideas from Gestalt therapy, object relations theory, and attachment models, SFT differs from classic CT in additional respects. One difference is in the therapist's role. While classic CT therapists typically view the relationship as a vehicle for motivating clients' engagement (e.g., with homework assignments), SFT therapists use the relationship itself quite extensively, in two main ways. First, it is a realm in which schemas, modes, and behaviors can be observed, assessed, and modified. Second, the relationship is used as a "corrective emotional experience" (20). Through what SFT terms "limited reparenting," the therapist acts in ways that serve as an antidote to early unmet needs (typically emerging from deficits in parental behavior or from a poor fit between the client's temperament and their early environment). Limited reparenting involves a flexible ability to partially meet the client's basic emotional needs – after determining what those needs are – and through that, to model a healthy adult approach that the client may internalize. Limited reparenting guides the therapist to fulfill unmet childhood needs, within the appropriate boundaries of a therapy relationship. Practically, it calls for warmth, acceptance, caring and validation, often exceeding those present in CT (let alone non-CBT approaches). For example, phone calls or emails are encouraged, as is appropriate therapist self-disclosure.

The main therapeutic stance of SFT is empathic confrontation, not collaborative empiricism. Therapists empathize with clients and validate the developmental factors that led to their schema view (i.e., to the hurt inherent in the vulnerable child mode and to probable reasons for the emergence of characteristic schemas or modes), while confronting them with the reality that the schema view is maladaptive and does not fit well with present-day reality. In mode terms, this requires specific "retorts" to those modes preventing the client's own healthy adult from nurturing and empathizing with their own vulnerable child.

Both CT and SFT models of PD stress the importance of strategic case conceptualization. Therapy is most effective when a collaboratively-created conceptualization of the case guides the selection of goals and tools in the therapy. A conceptualization is usually created early in the therapy based on an assessment period which may include structured or unstructured interviews, questionnaires, review of client self-monitoring, and (particularly in SFT) the use of imagery for assessment. Therapists often review the conceptualization with clients, and involve them in revising and refining it in a collaborative manner. Obviously, conceptualizations are revised as needed when therapy progresses.

Once the assessment/conceptualization phase is complete, treatment enters a change phase, whose explicit goal is for the clients to be able to have their core needs met in adaptive ways. In this phase, the therapist flexibly uses cognitive, emotional/experiential, behavioral, and relational/interpersonal strategies to change schemas and replace maladaptive coping styles with healthier forms of behavior. Though CT also uses technical eclecticism, it tends to maintain a strong emphasis on cognition; in contrast, SFT is often less cognitive in nature and relies more on affective/experiential tools, especially imagery work borrowed from Gestalt therapy (21).

To date, one RCT (22) has been published, comparing the efficacy of SFT to that of another established treatment for BPD: transference focused psychotherapy (TFP). Eighty-eight patients with BPD were randomly assigned to one of the two treatments, both comprising two weekly 50-minute outpatient sessions for three years. Analyses were conducted at both 1 and 3 years. Both groups improved on personality constructs, but SFT was superior on all outcome measures, including recovery (45.5% in SFT, 23.8% in TFP) and/or reliable change (65.9% and 42.9%, respectively) in BPD symptoms rated by independent interviewers. Similar results were found with self-reported quality-of-life and psychopathology. Importantly (given the topic of patient retention discussed earlier), the dropout rates were considerably higher for TFP (50%) than in SFT (25%). Among those

who dropped out, SFT patients had a median of 98 sessions (close to 1 year) vs. 34 sessions (roughly 4 months) for TFP patients.

SFT has been adapted for work with various populations besides BPD (e.g., homeless substance abusers, individuals with BPD or anti-social PD in forensic settings; 23, 24). However, there is only one additional outcome study: a non-randomized quasi-experiment of inpatients with Cluster C PDs and agoraphobia who received treatment as usual or an intervention combining cognitive therapy for agoraphobia with SFT (25). This study found reductions in interpersonal problems and in phobic anxiety for both treatments, with the cognitive/SFT approach yielding considerably stronger effect sizes (at follow-up: 0.88 and 1.82 in the cognitive/SFT group, vs. 0.55 and 0.01 in the TAU group, for the two outcome measures, respectively).

Dialectical Behavior Therapy

The "third wave" of behavioral approaches (26) has introduced a focus on acceptance and mindfulness into CBT. A leading example of this wave is Linehan's Dialectical Behavior Therapy (DBT; 27). The DBT approach was first developed for the treatment of suicidal and non-suicidal self-injurious behaviors, later became a leading treatment for borderline personality disorders, and more recently has been applied to other conditions (e.g., antisocial personality disorder in forensic settings, 28; binge-eating, 29; adolescent inpatients, 30).

DBT views individuals with BPD as characterized by trait-like emotion dysregulation, assumed to be temperamental, which leads them to respond to stressors with emotional reactions that have both a quick onset and a delayed offset. In addition, these individuals are assumed to have had (and often still have) an invalidating environment, in which their atypical emotional reactions were punished, denied, or responded to in other ways that conveyed that they, and their emotions, are intolerable. This interaction between temperament and environment is thought to lead to self-invalidation, to a simplistic view of emotions, and to desperate but usually futile attempts at self-regulation, attempts that underlie the pervasive instability in behavioral, interpersonal, affective, and self-identity domains.

DBT combines ideas from behavior therapy, cognitive therapy, and Zen Buddhism; the Buddhist notion of dialectics is very central and pervades the therapy. The therapist assumes a dialectic stance: on the one hand, accepting and validating the client's emotional pain; on the other, attempting to change the factors that cause stress as well as the behaviors that follow the emotions. This combined focus on thesis (acceptance) and anti-thesis (change) is just one of several dialectics. Another is the emphasis on combining rational (cold) and emotional (hot) thinking into what is termed "Wise Mind."

Standard and comprehensive DBT calls for a multi-layered treatment approach, which includes group (skills training) sessions, individual sessions, phone coaching when self-injury is imminent, involvement of family members, and weekly team consultation for the therapists. Though less comprehensive versions (which include only some of these components) are common, they are not considered to meet the requirements of the therapy, an important point to consider in implementing DBT or in evaluating its effectiveness based on efficacy studies.

A hierarchy of topics and goals guides DBT. In the first stage of therapy, these goals are (in order) to decrease (a) life-threatening behavior, (b) therapy-interfering behaviors, and (c) quality-of-life interfering behaviors, by (d) increasing skills that replace ineffective attempts at emotion-regulation. Considerable research, including several RCTs (e.g., 31, 32) supports the use of (comprehensive) DBT with BPD clients. Variants of DBT that are briefer (e.g., 33), appropriate for inpatient units (e.g., 34), and useful for specific populations (e.g., BPD with drug-dependence; 35) have also shown promising results. In the most well-powered of these RCTs, Linehan and colleagues (32) randomly assigned 101 women with BPD, all with both recent and past suicidal and self-injurious behaviors, to receive one year of DBT or of community treatment by (non-behavioral) experts (CTBE), with a one-year follow-up. CTBE differs from the more typical "treatment as usual" condition in controlling for several characteristics of the comparison therapists: their expertise (as judged by community mental health leaders), allegiance to their respective approaches, and prestige of supervision (conducted through a

psychoanalytic institute). DBT was conducted in its standard and comprehensive form (including individual and group sessions, phone consultations, and a mandatory weekly therapist consultation meeting. CTBE needed to be at least one hour a week, but could be supplemented as needed by ancillary treatments. In practice, patients received considerably more treatment hours in DBT than in CTBE, but when additional treatment utilization (e.g., day or inpatient hospitalization) was included, the two groups did not differ in therapy usage.

The strongest effects in Linehan et al.'s study (32) were in rates of suicide attempts (23.1% of DBT patients vs. 46.0% of CTBE patients) and ER visits (43.1% and 57.8%, respectively, in the first year of the study; 23.4% and 28.9% in the second year). Hospital admission rates differed along similar lines, as did drop out rates from therapy. Both treatments groups had no completed suicides, and both led to declines in (Hamilton rated) depression and in rates of self-injury; the decline rates did not differ between the groups.

Consistent with DBT's original focus on the reduction of life-threatening behaviors, DBT efficacy studies (e.g., 32) have focused on important behavioral outcomes – e.g., suicidality, self-injury, ER visits, and impulsivity – all defined as stage-1 outcomes. Nonetheless, clients often complete this first stage in a "quiet desperation" state; the following stages of therapy are intended to lead them to emotional experiencing (stage 2), adaptive solutions of "problems in living," including axis-I symptoms (stage 3), and the capacity for freedom and joy, the reduction of feelings of emptiness, and an increase in experiences in which they feel complete (stage 4). To date, no RCT has focused specifically on these advanced stages of DBT.

One recent RCT (36) compared DBT with two active treatments (supportive therapy and TFP, the same therapy to which SFT was compared [22]). Ninety patients with BPD were assigned to one of the three year-long treatments. DBT patients participated in weekly individual and group sessions; TFP patients attended two weekly sessions; and supportive therapy patients received one weekly session with additional sessions as needed. Compared to other studies (e.g., 32), a very large percentage of DBT patients dropped out of the treatment within nine months (43% compared to 23%-27% in the other therapies). The results reported are based only on those who completed at least nine months of treatment. All three treatments produced reliable change in various domains, yet TFP was associated with broader effects than DBT (or supportive therapy). Specifically, though both DBT and TFP lowered suicidality, depression, and anxiety, and improved both global functioning and social adjustment, only TFP was associated with reduced anger, impulsivity, irritability, and assault.

There are several concerns regarding the generalizability of this study (e.g., the surprisingly high dropout rate for DBT patients; the absence of adherence data for therapists). It does, however, suggest that even standard and comprehensive DBT may at times yield weaker results than those that have become associated with this approach.

Conclusions

CBT approaches clearly offer effective tools for addressing the enduring, hard-to-treat patterns of PDs. Nonetheless, these approaches have considerable room for improvement, both theoretically and empirically. Theoretically, though CBT models for specific PDs (or alternatively, for specific constellations of schemas, traits, or modes) have been proposed, extensive work remains in testing specific explicit and implicit cognitive hypotheses that derive from these models. Clinically, there is a strong need for controlled empirical tests of specific interventions for particular PD groups and for more advanced studies (e.g., dismantling designs, process-analytic studies) to increase efficacy, efficiency, and generalizability.

To be sure, some of the strongest effects of CBT treatments for PDs are on comorbid axis-I symptoms such as depression and anxiety. Indeed, until we dismantle these therapies, we cannot rule out general therapeutic factors (e.g., a strong alliance) as a major source of therapeutic effects. Yet if strong alliance alone were effective with PDs, competent clinicians would not have found these disorders so intractible, and the need for new treatment approaches would not have arisen. Instead, the studies conducted to date begin to demonstrate that these treatments address both hard behavioral

outcomes (e.g., suicidal behavior, ER visits) and softer psychological outcomes (e.g., quality of life, symptoms such as emptiness) that are unique to PDs.

One benefit of using CBT approaches in treating PDs is that they can be integrated seamlessly with CBT interventions for comorbid Axis-I disorders, so very common in clients with PDs. Since all three approaches described here advocate collaborative case conceptualization, use cognitive and behavioral tools, and expect patients to complete "homework" between sessions. These components are key in addressing all axis-I problems as well, and therefore do not require an abrupt shift in the therapy process.

Nonetheless, to treat the pervasive long-standing difficulties in PDs, CBT models have become integrative, incorporating additional philosophies (e.g., Buddhist mindfulness) or tools (e.g., imagery techniques) with CBT. These models may further improve by incorporating elements of each other, as well as of other evidence-based non-CBT approaches for the treatment of PDs (e.g., Bateman and Fonagy's mentalization based treatment, 37).

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