Cognitive Therapy of Patients with Personality Disorders

The cognitive model of mental function and psychopathology starts from a basic assumption that moods and behavior are the products of thought. Presented with a stimulus, a person will attribute some meaning to it, which will result in physical feelings, emotional sensations, communications, or behaviors. The meanings attributed to events are the products of automatic thoughts (ATs), ones that generally occur without active awareness. Maladaptive automatic thoughts result in dysfunctional behaviors and uncomfortable sensations. The simplest formulation of this concept is illustrated in Figure 1 (see page 134).1-3

Automatic thoughts are rooted in a person’s core beliefs (CBs) or “schemas.” (The two terms will be used interchangeably here.) CBs are stable assumptions about one-
self and the world. They can be adaptive (“I’m OK, and the world is safe”) or maladaptive (“I’m bad, and the world is dangerous”). Most people harbor both positive and negative CBs. The negative ones are transiently activated in times of stress and generate maladaptive ATs. These basic beliefs generate certain conditional assumptions, which are necessary conclusions that flow from the CBs. These assumptions then imply certain rules of behavior. The flow of assumptions, conclusions, and thoughts constitutes the cognitive conceptualization diagram, as illustrated in Figure 2 (see page 137).1,3,4

COGNITIVE FORMULATION OF PERSONALITY DISORDERS

People with straightforward Axis I disorders of depression and anxiety become symptomatic because of the activation of automatic thoughts. People with personality disorders (PDs) also suffer from distressing symptoms and dysfunctional behaviors resulting from maladaptive thoughts, but their ATs are based on more profound, powerful, and persistent core beliefs. Where the negative CBs of a person with, for example, generalized anxiety disorder, are activated only transiently, the CBs of a person with a personality disorder are active virtually all the time and afford no relief from negative thinking and the resultant sensations.

The cognitive model allows that there may be inborn or temperamental characteristics that predispose one to such schemas.5,6 Early traumatic experiences are overrepresented in the histories of patients with many PDs7 and shape the adoption of deeply rooted negative CBs. Mismatches of style and communication with parents or other early caregivers can lead to the adoption of distorted CBs and maladaptive schemas.8

The CBs of such people tend to be self-perpetuating for a number of reasons. The existence of strong negative CBs leads one to filter the factors to which he or she pays attention. A person who believes from early life on that she is worthless will pay more attention to perceived insults than to compliments, strengthening the conviction of the core belief and perpetuating the resulting assumptions and rules.4 Negative early beliefs force a child into inflexible modes of information processing, making the negative schemas particularly rigid. The developing child then misses out on the normative accumulation of interpersonal skills. Without such skills, he or she acts and communicates in ways that truly yield rejection and hostility from others, further accelerating the cycle.9 Even the compensatory strategies they adopt within themselves require near perfection and are impossible to maintain. When the strategy fails, the person suffers more disappointment and tries the same strategy even more.10

People who grow and develop in such a dysfunctional pattern are left almost exclusively with negative CBs. People without PDs may have some negative core beliefs, but they are usually able to balance them against the greater weight of concurrent positive CBs. Even under stress, they still have positive schemas in reserve. PD patients do not have such a reserve and are always at risk emotionally.4 The CBs of some personality disorders, particularly the Cluster B types, are often contradictory, and the person is not able to equilibrate them with normal ambivalence. The result is a rapid shifting of schemas, resulting in affective instability and seemingly impulsive behavior.8,10

In all cases, the cognitive formulation, just like the psychodynamic formulation, is that adaptations that may have worked at some stage of development became overdeveloped, to the exclusion of others, and are currently being applied in situations and environments where they no longer work well.2,5 Cer-
tain patterns are characteristic of some PDs, as outlined in the Table.

**COGNITIVE APPROACHES TO PERSONALITY DISORDERS**

In the usual treatment of mood and anxiety disturbances in people without personality disorders, the underlying schemas shape the pathogenic automatic thoughts. However, treatment is usually effective focusing only at the level of the ATs. Most often, core beliefs do not need to be addressed in depth.1,2 When people with personality disorders come for treatment, it is almost always because of symptomatic manifestations such as depression or anxiety that do not immediately reveal the presence of a PD. Before long, however, the therapist may note any of several indicators of personality pathology:

- Attempts to address ATs are notably unsuccessful because of rigid underlying beliefs.
- A significant other, or the patient him or herself, says he or she “has always been that way.”
- The patient is consistently uncooperative with the treatment regimen.
- Therapeutic movement comes to a sudden stop for no obvious reason.
- The patient is remarkably unaware of the effect of his/her behavior on others.5

Because maladaptive schemas are at the core of personality disorders, the core beliefs are the ultimate focus of cognitive behavioral therapy (CBT) in people with PDs.2,4 Although the therapist is likely to begin by identifying ATs, ultimately the therapist and the patient must come to recognize together the existence of the core beliefs. Articulating and drawing the cognitive conceptualization diagram is often helpful (see Figure 2, page 137). Frequently, the patient may need to work backwards from acknowledged ATs through the conditional assumptions and rules before arriving at the CBs.2,5

The nature of the pathology and the treatment goals dictates some particular characteristics of CBT with personality disorder patients compared with those who have depression or anxiety without PDs:11,12

- Therapy takes longer. Identification of ATs and correcting them with standard techniques most often requires 8 to 20 sessions of CBT. In people with PDs, therapy usually takes months, often years, because the maladaptive schemas are so pervasive and so resistant to change.
- Goal setting requires more active therapist involvement. Most patients with standard Axis I disorders will require little assistance in turning their wish for improvement into identifiable goals, such as “I want to be able to get through the day without crying.” Patients with PDs are more likely to start with vague, indefinable, and unattainable goals such as, “I want to feel OK.” Identifying realistic and specific goals is necessary before work can begin and may take many sessions.
- There is more focus on the doctor-

<table>
<thead>
<tr>
<th>Personality Disorder</th>
<th>Beliefs about Self</th>
<th>Beliefs about Others</th>
<th>Assumptions</th>
<th>Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avoidant</td>
<td>Vulnerable; undesirable; socially inept</td>
<td>Critical; rejecting; superior</td>
<td>Rejection is terrible; if people know me, they will reject me</td>
<td>Avoid judgmental situations; avoid unpleasant emotions</td>
</tr>
<tr>
<td>Dependent</td>
<td>Needy; weak; helpless</td>
<td>Competent; supportive; nurturing</td>
<td>Need sources and expressions of support; need others to survive</td>
<td>Rely on others; cultivate nurturing relationships</td>
</tr>
<tr>
<td>Obsessive-compulsive</td>
<td>Responsible; fastidious; competent</td>
<td>Irresponsible; careless; self-indulgent</td>
<td>Details are crucial; I know what’s right</td>
<td>Control, evaluate, criticize; strive for perfection</td>
</tr>
<tr>
<td>Narcissistic</td>
<td>Unique; superior; exempt from social rules</td>
<td>Inferior; admiring</td>
<td>I’m better than others; I’m above regular rules</td>
<td>Use others, manipulate; ignore rules, demand special treatment</td>
</tr>
<tr>
<td>Borderline</td>
<td>Defective; bad; helpless</td>
<td>Untrustworthy; abandoning</td>
<td>If I depend on myself, I won’t survive. If I depend on others, I will be abandoned</td>
<td>Express extremes of emotion and behavior; present contradictory demands</td>
</tr>
</tbody>
</table>
patient relationship. In patients with PDs, the distorted interpersonal perceptions and responses are so powerful that therapy often cannot proceed unless the therapeutic relationship is specifically addressed.

- The therapist must examine his or her own feelings and beliefs. Just as focus on transference requires accurate assessment of countertransference, the cognitive therapist of a PD patient must be consciously aware of his/her own beliefs about the patient, him or herself, the therapy, and the world in which they all operate.

- Patients may enter therapy lacking some necessary skills. Many depressed or anxious people have simply put available cognitive and behavioral skills “on hold” and can reactivate them in therapy. Patients with PDs often did not develop basic skills necessary even to participate effectively in therapy, such as ways of perceiving and communicating with others. Therapy thus requires episodes of skills training.9,12,13

With these principles as a background, we can now look at cognitive formulations, therapeutic strategies, and particular techniques in several specific personality disorders, in roughly increasing order of therapeutic challenge.

**CBT OF SPECIFIC PERSONALITY DISORDERS**

**Avoidant Personality Disorder**

The ATs and schemas activated in avoidant PD have much in common with depression in people without PDs, and may thus call for the most moderate adaptations of traditional CBT. Such people want affection but fear rejection. Their core beliefs are marked by such tenets as, “I’m inept” and “Others will reject me.” They are predisposed to perceive rejection, even when none is intended and are prone to draw such conclusions as, “Because people reject me, it must be because I’m bad.” Their automatic thoughts are populated by ideas such as, “I’m boring” and “I’m dumb.”

Avoidant people make negative predictions about social situations, which often become self-fulfilling. Feeling rejected, they will become dysphoric. But these individuals have a low tolerance for emotional discomfort and will quickly leave the social setting. Commonly, they will think they need to maintain a façade of competence and good cheer. Even if the appearance is successful, they feel like failures: “I just fooled them.”

This cluster affects the patient’s approach to therapy. Awkward and fearful interpersonally, they are usually reluctant to share candidly with a therapist and may not believe that the therapist’s caring is genuine. Reflections about negative ATs or patterns of self-defeating behavior are likely to be heard as deserved criticism. Because withdrawal is a common behavioral response, they may fail to complete homework assignments rather than risk criticism.

One of the first therapeutic steps can be to diagram the process of avoidance. (See Figure 3, page 137.)

Emphasizing the protective intent of the avoidance allows the patient to feel understood rather than judged. Next, the therapist can explore with the patients the negative consequences, such as loneliness, which result from this strategy. When the patient is able to entertain the idea of alternative thoughts and solutions, the next step is to identify a hierarchy of tension-producing situations. Starting with the least provocative situation, the therapist has the patient form a mental image of it in the session. As the patient proceeds through his or her ATs and their consequences, the therapist

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A person who believes from early life on that she is worthless will pay much more attention to perceived insults than to compliments, strengthening the conviction of the core belief and perpetuating the resulting assumptions and rules.
to take the role of imagined others and for the therapist to act the part of the patient. In this way, the patient can more realistically imagine the views of others, and the therapist can demonstrate ways of getting along that may be new to the patient.3,4,5

Dependent Personality Disorder

The criteria for dependent personality disorder have much in common with those for depression, such as helplessness and indecisiveness, so dependent patients will often present with a depressive disorder. In their system of CBs, they are inherently unable to help themselves, so the world is a cold and frightening place. The solution is to find someone to take care of everything, but then the person risks rejection. Behaviorally, such people become careful to please others, but usually cannot avoid coming across as desperately clingy, often fulfilling their own prophecies of abandonment. Automatic thoughts are often, “I’m incapable” or “I’m weak.”

The therapist may get caught in the patient’s need to see him or her as an expert and to avoid self-expression. Meticulous application of Socratic techniques is necessary to let the person discover his or her patterns and own the discoveries. In setting goals, the patient may view any hint of autonomy as frightening, so goals are best set in terms of concrete accomplishments. In setting the agenda for individual sessions, the therapist may need to take the patient’s comments from introductory discussion and translate them into the agenda items that the patient is too insecure to propose.

An advantage/disadvantage table can help the patient become motivated for change. Dividing a sheet into four quadrants, the patient lists advantages and disadvantages of changing behavior, and of maintaining behavior. Nearly always, the balance sheet favors change, and the ideas belong to the patient.1 These patients may overrate their skills deficits, which can be tested in the therapy. For example, a patient who believes he is incapable of maintaining a conversation can be played a tape of the session. Role playing is also useful in this regard as well.3

Such patients may fear making prog-
ress because it implies autonomy, which equals isolation. The therapist must maintain constant attention for signs of such a distortion. Similarly, termination is a scary proposition, and should be handled gradually and with open acknowledgement.5

**Obsessive-Compulsive Personality Disorder**

People with obsessive-compulsive personality disorder (OCPD) believe in the power of perfectionism and the existence of a single right answer to every problem. Such CBs yield automatic thoughts such as, “Any mistake will be a disaster,” or “Ambiguity is intolerable.” The usually futile search for correctness leads to problems of doubt and procrastination, which can produce symptomatic anxiety or depression. Interpersonal situations always require a tolerance of ambiguity, so the insistence of OCPD patients on absolutes is usually socially maladaptive, and difficulties in this realm will often be the impetus to seek therapy.5

Because perfectionism is not without reward, there is enough positive feedback to perpetuate the cycle. It is a particular problem that the same core certainty in the correctness of their thinking makes these people committed inflexibly to their maladaptive core beliefs. Although the therapist may be tempted to set relaxation and flexibility as goals, patients will usually see these ends as undesirable. Instead, early goals focus on the mood or behavioral symptoms bothering the patient at the outset. In the process of applying CBT tools to these issues, characterologic issues of inflexibility will invariably emerge and can then become a secondary focus of intervention.

OCPD patients, for example, will often be reluctant to complete homework assignments because they fear that making a mistake is worse than not doing the assignment at all. One may address this problem paradoxically by recommending a homework assignment that the patient deliberately fills out one of the CBT worksheets incompletely or incorrectly. Afterwards, it is possible to review the fears and actual consequences of such imperfection. Ultimately, such forms can help the patient put names to feelings and identify the emotions underlying maladaptive behavior patterns. OCPD patients usually take well to problem solving, and advantage/disadvantage worksheets play to their strengths. They are often better at dealing with their automatic thoughts at arm’s length and can make use of reverse role play as described above.14

**Narcissistic Personality Disorder**

Narcissistic people by definition regard themselves as exceptional and believe that the world owes them special treatment. Invariably, the world does not share these beliefs, so when NPD patients come to therapy it is often with feelings of depression because of the conflict between their beliefs and reality or because of the expectable interpersonal difficulties. Automatic thoughts are ideas such as, “I’m too good for this situation,” or “Others don’t give me what I deserve.”

Such people may question the therapist’s qualifications and authority before any therapy begins. Typically, they will rebel against the structure of CBT because rules are meant for others, and their own problems are unique. It is particularly important with NPD patients to use their identified problems and goals, which usually focus on the shortcomings of others and derive patterns of perception and behavior across situations. One must accommodate the grandiosity and hypersensitivity of such patients in implementing CBT tools. Feedback is usually requested toward the end of every CBT session. With NPD patients, it may be elicited earlier and more often.

By examining patterns of perception and response, the therapist introduces alternative formulations, such as, “I can be human and still be unique,” or “There is gratification in being part of a team.” Imagery techniques can reveal grandiose fantasies and can be used to modify them with more realistic solutions. Role-playing can be used to teach and exercise awareness of the feelings of others. Behavioral experiments can include specific actions that benefit others, such as calling a neglected friend.2,5,13
Borderline Personality Disorder

The treatment of borderline personality disorder poses as significant a challenge for cognitive therapists as it does for practitioners of psychodynamic, supportive, or other brands of psychotherapy. The evidence for the pathogenic role of early trauma in BPD is more convincing than it is for any other personality disorder. These patients commonly report negative childhood experiences, recalling their family environments as unsafe, unstable, punitive, and lacking in nurturance. At an early age, they incorporate beliefs that others are dangerous or malignant, that they themselves are vulnerable and powerless, an that they are inherently bad and undesirable. These themes are embedded in the cognitive frame with notable rigidity; they also form selective filters on perception so that experience only solidifies the CBs.

A range of compensatory strategies may be adopted: “I must appear competent;” “The expression of feelings leads to rejection;” and “Because others reject my feelings, they must be invalid.” To further accelerate the cycle, such children often lack the modeling or coaching in adaptive expressions of emotion and grow up with serious deficiencies in these skills. In adulthood, they thus display dramatic instability of moods with rapid shifts from one set of beliefs to another, accounting for their commonly “irrational” clinical presentations.

BPD patients will come to treatment with an array of mood and interpersonal disturbances. The therapist’s attempts to uncover ATs will soon yield a bewildering and rapidly shifting array. The first task is the establishment of a working relationship, tolerant of the patient’s ambivalence, acknowledging his/her difficulties with trust. Once there is a working relationship, the therapist is careful not to accept the patient’s assumption that every symptom is a crisis. The goal is to manage symptoms, not to eliminate them. For example, urges to self-harm may persist, but the therapist may help the patient find less destructive ways to channel the urges, such as tearing up a picture of oneself instead of cutting one’s wrists.

Changing the automatic thoughts is generally done in an experiential context, and frequently requires learning and practicing new skills. When patient and therapist discover more adaptive ways to process experiences, the patient can write them on note cards and review them before provocative encounters. Role-playing is also useful in practicing new social skills, to disrupt the cycle of perceived rejection, disruptive behavior, and actual rejection. As ATs are addressed and underlying schemas come to light, imagery can be used to recall early experiences. Reliving them with the therapist present can diminish their noxious influence, and they can be reimagined with less destructive outcomes. Termination is rarely complete. Treatment may be episodic, with an emphasis toward the end of each episode on relapse prevention, using techniques such as notes and recordings of the therapy, and structured self-therapy sessions.

CONCLUSION

Evidence supports the usefulness of CBT in the treatment of people with a range of personality disorders. Improvement in symptomatic measures, such as the Symptom Checklist-90 and various yardsticks of depression and anxiety, usually come earlier than changes in personality structure. The likelihood of improvement depends on the patient’s persistence in the therapy, mandating analysis, and maintenance of the therapeutic alliance. Compared with CBT for uncomplicated Axis I disorders, cognitive therapy for PDs takes longer, requires more intensive exploration of the historical roots of the problems, pays closer attention to the doctor-patient relationship, and requires a great deal of flexibility.

REFERENCES
