Cognitive Therapy for Personality Disorders

A Guide for Clinicians

SECOND EDITION

Kate Davidson

Cognitive Therapy for Personality Disorders

It is increasingly recognised that a significant number of individuals with personality disorders can benefit from therapy. In this new edition – based on the treatment of over a hundred patients with antisocial and borderline personality disorders – Kate Davidson demonstrates that clinicians using cognitive therapy can reduce a patient's tendency to deliberately self-harm and to harm others; it also improves their psychological well-being. Case studies and therapeutic techniques are described as well as current evidence from research trials for this group of patients.

Cognitive Therapy for Personality Disorders provides a thorough description of how to apply cognitive behavioural therapy to patients who are traditionally regarded as being difficult to treat; those with borderline personality disorders and those with antisocial personality disorders. The book contains detailed descriptions and strategies of how to:

- formulate a case within the cognitive model of personality disorders
- overcome problems encountered when treating personality disordered patients
- understand how therapy may develop over a course of treatment.

This clinician's guide to cognitive behavioural therapy in the treatment of borderline and antisocial personality disorder will be essential reading for psychiatrists, clinical and counselling psychologists, therapists, mental health nurses, and students on associated training courses.

Kate Davidson is Honorary Professor of Clinical Psychology at the University of Glasgow and Director of the Glasgow Institute of Psychosocial Interventions, NHS Greater Glasgow and Clyde. She has contributed extensively to the literature on personality disorders and mental health, with publications including *Life after self-harm*.

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Second edition

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Preface

This is the second edition of *Cognitive therapy for personality disorders: a guide for clinicians*, the first having been published in 2000. Since then, there has been an increase in clinicians seeking evidence-based treatment approaches to personality disorder as well as political interest in personality disorder. An extensive review of the literature shows that some approaches currently have a scientifically rigorous evidence base and can be applied in everyday clinical settings. Clinicians are being asked to provide evidence-based practice and this book will be an excellent source for clinicians wishing to have guidance in psychological therapy with patients with personality disorder.

This revised edition is substantially changed from the first edition. The additions and revisions include an updated section on the long-term prognosis for personality disorder in the light of new evidence that challenges previous assumptions that borderline personality disorder is longstanding and does not change. Although there is some evidence that the prognosis for borderline personality disorder may be better than was previously thought, those with borderline personality disorder may continue to have poor social functioning in the longer term. Other cognitive therapies and models are described in this new edition. In addition, there is a review of randomized controlled trials for borderline personality disorder and information on the evidence for cognitive behavioural therapy that is available to date. New case material has been added throughout the book that illustrates the problems and experiences of those with borderline and antisocial personality disorders. The book gives examples of how to use cognitive therapy to help ameliorate the more common problems encountered by clinicians when treating individuals with personality disorder.

The clinical insights in this new edition have come from direct experience of treating individuals with borderline and antisocial personality disorders with cognitive therapy and from learning from therapists who undertook the challenging task of treating patients with these disorders in clinical trials. We have all learned from our patients with antisocial and borderline personality disorders and we are grateful to them for being willing to enter into therapy

and the journey we have taken together. We thank these patients for the help they have given us. Their feedback was always helpful, even when we suggested things that were not useful and, of course, when cognitive therapy helped improve their lives.

We now have a strong case for suggesting that cognitive therapy can help individuals with personality disorder. This therapy is highly applicable in routine clinical settings in the community and can be undertaken by cognitive therapists trained to follow this model who have access to appropriate clinical supervision. Cognitive therapy is time limited and problem focused. It has the characteristics that allow patients, thought to be difficult to engage in services and therapy, to readily engage in this process with good outcomes.

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Chapter 1

Background

In the past twenty or so years, more thorough and systematic study of personality disorders has increased our knowledge and understanding. Personality disorders are now known to be common and many individuals with personality disorders may manage their lives satisfactorily without intervention. However, we recognize that significant numbers of individuals with personality disorders seek help with the problems they experience and the distress they, and others, suffer. We now recognize that people with personality disorder should be able to access appropriate clinical care and management from mental health services, and that the staff providing this help need to be properly equipped with the skills to offer help (National Institute for Mental Health England, 2003). There is a responsibility to ensure that individuals with personality disorder get appropriate care and are offered therapy that is likely to be effective.

What is personality disorder?

Interest in abnormal personality has increased since 1980 when the American diagnostic system first described personality disorders (American Psychiatric Association (APA), 1980). These original descriptions were not based on theory but were derived from a consensus agreement among informed clinicians and researchers who wished to classify the personality traits seen in clinical settings. In the 1994 *Diagnostic and statistical manual*, 4th edition (DSM-IV), the APA defined personality traits in terms of enduring maladaptive patterns of perceiving, relating to, and thinking about the environment and oneself, exhibited in a wide range of important and social contexts (APA, 1994). The term "personality disorder" is used when such personality traits result in impairment in the way an individual functions in a social or occupational context or when these traits result in distress to that individual. These traits are understood to begin in adolescence and to be recognizable in adulthood, and are therefore regarded as being long-lasting and relatively stable.

Different views are held about the concept of personality disorder (Strack and Lorr, 1997). Implicit in the diagnostic system is the notion that individuals

with personality disorder are distinct from those with normal personality by having a physical, biological or genetic abnormality. Not all researchers and clinicians agree with this view and many argue that the distinction between normal and abnormal personality is a matter of degree and that personality traits are more fully and usefully described on dimensions rather than categories. Another view is that those with personality disorder share the same personality traits as found in others but these are expressed in a qualitatively different way, reflecting a more rigid underlying character structure. Although these conceptualizations differ, they are not mutually exclusive. The cognitive theory of personality disorder gives a central role to schemas and to preprogrammed patterns of behaviour or strategies that through evolution promoted individual survival and reproduction in personality disorder (Beck *et al.*, 1990). It is thought that schemas arise from an interaction between biological predispositional factors and childhood environment. The underlying cognitive, affective, arousal and motivational patterns or schemas affect the way information about the self or the environment is selected and processed.

Assessment of personality disorder

There has been a growth in the number of semi-structured clinical interviews and self-report questionnaires for assessing personality disorder. Table 1.1 describes some of these instruments.

Standardized assessments are more reliable than clinicians' judgements but there is still no consensus as to how best to assess personality disorder. There appears to be poor agreement between instruments used to assess personality disorder and not all instruments cover all personality disorders. Most interview-based instruments are more reliable when used by trained interviewers with several years of clinical experience. The advantage of interviewing subjects is that the false positive rate for the presence of a personality disorder is likely to be kept to a minimum as the interviewer has the opportunity to ask subsidiary questions to clarify the severity and extent of each personality trait and to make an informed clinical judgement. Also, the degree to which the subject is literate is less problematic in an interview setting whereas literacy level is critical if self-report instruments are used. It is unclear if the same instruments will provide as good reliability if used by independent researchers and it is unclear if patients or informants provide the least biased view of the patient's usual personality traits. In addition, self-report questionnaires appear to give much higher prevalence rates of personality disorder than structured interviews and are probably best used as screening instruments.

Individuals may not recognize the maladaptive nature of their perception, cognition, mood and behaviour and asking an individual to estimate their own degree of abnormality may be problematic if they already have a different baseline of problematic personality traits and behaviour from that

Table 1.1 Measures of personality disorder

Instrument	*Type*	*Reference*
International Personality Disorder Examination Revised (PDE-R)	Interview	Loranger *et al.*, 1987, 1994
Structured Clinical Interview for DSM (SCID-II)	Interview (includes a self-report questionnaire as screen)	Spitzer *et al.*, 1990
Structured Interview for DSM-III-R Personality (SIDP-R)	Interview	Pfohl *et al.*, 1989
Personality Assessment Schedule (PAS)	Interview	Tyrer *et al.*, 1988
Personality Diagnostic Questionnaire Revised (PDQ-R) (PDQ-4)	Self-report	Hyler *et al.*, 1988; Hyler, 1994
Millon Clinical Multiaxial Inventory (MCMI-III)	Self-report	Millon *et al.*, 1994
Schedule for Nonadaptive and Adaptive Personality (SNAP)	Self-report	Clark, 1993
Dimensional Assessment of Personality Pathology – Basic Questionnaire (DAPP-BQ)	Self-report	Livesley and Jackson, 2004

which would otherwise be considered normal. Asking an individual to assess their own personality traits requires an ability to self-reflect and an awareness of the degree to which a pattern of thinking, feeling and behaviour is consistent in the self across time. Some traits may be more culturally desirable than others and individuals who are sensitive to perceived social norms and values may alter their endorsement of items according to how they wish to represent themselves and who is enquiring. Partly for this reason, many assessments of personality disorder use reports from knowledgeable informants, though agreement between informants and subjects is not always high (Bernstein *et al.*, 1997; Zimmerman, 1994).

Although the diagnosis of personality disorder requires that personality traits be enduring, personality traits may fluctuate with the presence of a clinical syndrome and this may distort both the presentation and assessment of traits (Klein, 1993). For example, this problem is particularly apparent in the diagnosis of borderline personality disorder in which affective instability is a key feature. Many patients with a diagnosis of borderline personality disorder suffer from affective disorder or have chronic depressive features that are difficult to separate out from the characteristics of borderline personality disorder. This has led some researchers to view borderline personality disorder as an affective spectrum disorder (Akiskal *et al.*, 1985).

The diagnostic categories of personality disorder have been largely derived from clinical samples where entry into a health care system may have been influenced by the presence of a clinical syndrome or an acute crisis. A more accurate assessment of personality disorder may be obtained by assessing an individual during a period of remission from a clinical disorder or at more than one point in time. For a thorough review of assessment and related issues the reader is referred to other sources (Zimmerman, 1994; Weissman, 1993; Jackson, 1998).

Dimensional or categorical classifications?

Personality involves more than simply a collection of basic traits, and the clinical concept needs to reflect more than just the maladaptive expression of these traits. The clinical concept of personality disorder has to include the integration and coherence of these traits and how they relate to an individual's sense of identity and life goals and direction (Livesley, 2001). Although current systems of personality disorder classification are categorical, many researchers are critical of this approach. Some researchers argue that a dimensional classification may be more appropriate as the boundaries between discrete personality disorders may be artificial and the difference between normal and abnormal personality is better represented as a continuum (Widiger, 1992; Cloninger, 1987). A dimensional view of personality has the advantage of not giving any one trait special significance, of being more comprehensive in its description and in representing personality disturbance in terms of severity rather than categories. In addition, if personality disorders were not dichotomous, then measures that rely on dimensions would include more information than categories and would enable more reliable measurement (Loranger *et al.*, 1994).

Alternative approaches, arising from mainstream academic psychology with its lengthy history of research in personality using psychometric analysis, may be clinically useful in describing more fully the negative traits associated with personality disorder. The NEO-PI-R (Costa and McCrae, 1992) has shown that individuals with diagnosable personality disorders differ in predictable ways on the five dimensions of neuroticism, extraversion, openness to experience, agreeableness and conscientiousness (Widiger and Costa, 1994). Other measures of dysfunctional traits, such as the Schedule for Nonadaptive and Adaptive Personality (SNAP), which measures traits relevant to personality disorder, may also be useful in investigating theoretical hypotheses on the structure of personality disorder (Clark, 1993). It is clear that there appears to be increasing rapprochement between academic and clinical researchers in this area and it is likely that both normal and abnormal personality will be construed in dimensions, but with some overlap between the approaches, in the future (Deary and Power, 1998).

Key features of individual personality disorders (DSM-IV)

General criteria

It is important to note that an individual cannot meet criteria for a personality disorder unless the disorder is evident in a broad range of circumstances, has led to significant distress or impairment in social or occupational functioning and is not due to mental or physical illness or the physiological effects of drugs. The disorder has to be manifested in at least two of the following domains: thinking, affect, interpersonal relationships and impulse control. In addition, the disorder has to be stable and longstanding and present since early adulthood, if not adolescence.

Paranoid personality disorder

This is characterized by a pervasive distrust and suspiciousness of others, who are regarded as malevolent (APA, 1994). At least four of the following characteristics have to be evident:

- without sufficient basis, is suspicious that others are exploiting, harming or deceiving
- is preoccupied with doubts about trustworthiness or loyalty of others
- is reluctant or fearful of confiding
- reads hidden demeaning or threatening meaning into events
- bears grudges
- perceives others as attacking character
- has recurrent unjustified suspicions regarding fidelity of partner.

Schizoid personality disorder

This is characterized by a pattern of detachment in relationships and a restricted range of emotional expression in interpersonal situations (APA, 1994). At least four of the following characteristics have to be evident:

- avoids close relationships
- chooses solitary activities
- avoids sexual experiences with others
- has few pleasurable activities
- has few close friends or confidantes
- is indifferent to praise or criticism
- is emotionally cold or flat.

Schizotypal personality disorder

This personality disorder is described as "a pattern of acute discomfort in close relationships" and "cognitive or perceptual distortions and eccentricities in behaviour" (APA, 1994). At least five of the following characteristics have to be evident:

- ideas of reference (e.g. events are thought to have special personal significance)
- odd beliefs or magical thinking
- unusual perceptual experiences
- odd thinking or speech
- is suspicious
- inappropriate or restricted affect
- odd, eccentric behaviour or appearance
- no friends or confidantes
- high anxiety in social situations associated with paranoid fears.

Antisocial personality disorder

This disorder is described as a "pervasive pattern of disregard for and violation of the rights of others" (APA, 1994). Three of the following have to be evident:

- failure to conform to social norms with repeated unlawful behaviour
- deceitfulness
- impulsivity
- aggressiveness and irritability
- disregard for safety of self or others
- irresponsible behaviour
- lack of remorse.

Histrionic personality disorder

This disorder is characterized as a pattern of excessive emotionality and attention seeking (APA, 1994). At least five of the following criteria have to be evident:

- needs to be centre of attention
- inappropriate sexually seductive behaviour
- shallow expression of emotion
- physical appearance is attention seeking
- speech style is impressionistic and lacking detail
- exaggerated theatrical expression of emotion

- suggestible
- misjudges closeness in relationships.

Borderline personality disorder

This is a pattern of instability in personal relationships, self-image and affects, and marked impulsivity (APA, 1994). At least five of the following criteria have to be evident:

- fear of abandonment
- unstable and intense personal relationships
- identity disturbance
- impulsivity
- recurrent deliberate self-harm
- unstable affect
- feelings of emptiness
- difficulties controlling anger
- stress-related paranoid ideas or dissociation.

Narcissistic personality disorder

This disorder is described as a pattern of grandiosity and need for admiration, with lack of empathy (APA, 1994). At least five of the following characteristics have to be evident:

- grandiose self-importance
- fantasies of success, power, beauty or love
- regards self as special or unique
- need for excessive admiration
- sense of entitlement
- exploitative interpersonally
- lacks empathy
- envious
- arrogant.

Avoidant personality disorder

This is described as a "pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation" (APA, 1994). At least four of the following characteristics have to be evident:

- avoids activities involving interpersonal contact
- only becomes involved if certainty that will be liked by others
- restrained in interpersonal relationships

- fears criticism or ridicule
- feelings of inadequacy in new interpersonal situations
- views self as socially inept or inferior
- reluctant to take personal risks because of fear of embarrassment.

Dependent personality disorder

This is characterized as a "pattern of excessive need to be taken care of that leads to submissive behavior and fears of separation" (APA, 1994). At least five of the following characteristics have to be evident:

- requires excessive reassurance to make everyday decisions
- need for others to assume responsibility
- fears disagreeing with others
- lacks confidence initiating activities
- excessive need for nurturance
- fear of being alone
- quickly seeks another close relationship if one ends
- fear of abandonment.

Obsessive-compulsive personality disorder

This is a "pattern of preoccupation with orderliness, perfectionism, and mental and interpersonal control at the expense of flexibility, openness and efficiency" (APA, 1994). At least four of the following characteristics have to be evident:

- preoccupation with rules and detail
- perfectionism
- overemphasis on work and productivity at the expense of relationships and leisure activities
- overconscientious
- hoards objects
- unable to delegate
- miserliness
- rigidity and stubbornness.

Personality disorder not otherwise specified

This category in DSM-IV (APA, 1994) is for disorders of personality where an individual may have several of the characteristics of different personality disorders but does not fit any one of the specific personality disorders listed above.

Classification systems

In the American diagnostic system, personality disorders and clinical syndromes such as major depression, anxiety disorders and schizophrenia are diagnosed on different dimensions or axes. Personality disorders are diagnosed on Axis II in DSM-IV (APA, 1994) whereas clinical syndromes are diagnosed on Axis I. The implication of making personality disorder diagnoses on a separate axis is that this type of disorder is thought to exist continuously from late adolescence and is not associated with a condition that is characterized by a relapsing course or that remits like a typical illness syndrome. Rather an individual with a diagnosis of personality disorder will display attributes that are relatively enduring and persistent and are unlikely to show much variation in that the traits will be observed in a wide number of environmental and interpersonal contexts. This results in a lack of flexibility and adaptability as the individual has a narrow and limited range of coping styles.

In the International Classification of Diseases system, ICD-10 (World Health Organisation, 1992a), personality disorders are coded on the same axis as mental disorders. This classification system is similar to DSM except that different names are used for broadly similar types of personality disorders and in each system there are a number of disorders that do not appear in the other. For example, ICD-10 uses the term "dissocial" to describe the personality disorder referred to as antisocial in DSM-IV, anankastic personality disorder in ICD-10 is referred to as obsessive-compulsive in DSM-IV and anxious personality disorder is referred to as avoidant in DSM-IV. Narcissistic and passive aggressive personality disorders are not found in ICD-10.

In addition, unlike ICD-10, DSM-IV has grouped personality disorders into clusters, with the assumption that these clusters may have some shared attributes. DSM-IV personality disorder clusters are given in Table 1.2.

Table 1.2 DSM-IV personality disorder clusters

DSM cluster	*Personality disorder*
Cluster A: Odd or eccentric	Paranoid Schizoid Schizotypal
Cluster B: Flamboyant and dramatic	Antisocial Borderline Narcissistic Histrionic
Cluster C: Fearful or anxious	Avoidant Dependent Obsessive-compulsive

How common is personality disorder?

Community estimates of personality disorder may misclassify individuals or overestimate the prevalence of personality disorder in the community. This is partly because information from other sources is not accessed, and individuals are usually assessed by completing questionnaires asking about the presence or absence of a particular trait or behaviour. In the United States, estimates of the prevalence rates of any DSM-III personality disorder range from 10.3 to 11.1 per 100 in surveys of non-clinical populations (Zimmerman and Coryell, 1990; Reich *et al.*, 1989) using the self-report Personality Diagnostic Questionnaire (PDQ) (Hyler *et al.*, 1983). Using a two stage method in which only subjects who were screened as positive for personality disorder on a self-completion personality disorder inventory were interviewed by clinicians, the point-prevalence estimate for DSM-III-R personality disorder in a student population obtained a similar rate of 11.01 per cent (Lenzenweger *et al.*, 1997). This sample may, however, be unrepresentative of the population. Further data analysis from the British National Survey of Psychiatric Morbidity, using a two phase survey, suggests that the prevalence of personality disorder in the UK is around 4.4 per cent (Coid *et al.*, 2006).

Cluster A – prevalence

When prevalence rates of categories of personality disorders are investigated in community samples, the rates vary with the specific personality disorder, the sample size, the method of sampling and the assessment measure utilized. Within Cluster A, schizotypal is the most prevalent personality disorder in this group (up to 5.6 per 100) and paranoid personality disorder appears to be least prevalent, with reported rates of between 0.4 and 1.8 per 100 (Weissman, 1993). In the UK, these rates are similar with a weighted prevalence of 1.6 per 100 reported, though paranoid (0.7) and schizoid (0.8) personality disorder was more common than schizotypal (0.06) (Coid *et al.*, 2006).

Cluster B – prevalence

In Cluster B (antisocial, histrionic, borderline and narcissistic), antisocial personality disorder has the highest prevalence rate, varying from 2.1 to 3.7 per 100 in a North American community sample (Widiger and Corbitt, 1995) and a lower rate is noted for a UK community sample (0.6 per cent) (Coid *et al.*, 2006). This diagnosis is associated with notably higher rates in males compared to females and higher rates in younger as opposed to older males. In community surveys narcissistic personality disorder is low in prevalence, with two studies reporting a rate of 0.4 per 100 (Zimmerman and Coryell, 1990; Reich *et al.*, 1989). One study carried out as part of the Epidemiological Catchment Area (ECA) programme in Baltimore, USA, found a prevalence rate of 2.2