

ARTICLE

Treatment of personality disorder: skills-based therapies

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SUMMARY

A variety of therapies have been developed or adapted to treat personality disorder over recent years. This article will review skills-based treatments (as opposed to insight-based treatments). Two approaches are outlined: cognitive-behavioural therapy and dialectical behaviour therapy. The article details the underpinning theory and the model of personality disorder utilised by the two approaches, and describes how the therapy is applied. Evidence of therapeutic efficacy is presented along with information about accessing training and therapy materials.

DECLARATION OF INTEREST

S.E. is employed by Nottinghamshire Healthcare NHS Trust.

Until recently, many practitioners regarded personality disorder as untreatable. Although initially seeming to be suitable for therapy, patients with personality disorder were often difficult to engage, attended therapy sporadically and their self-damaging and violent behaviours interrupted treatment (Warren 1996). Many failed to improve with treatment, engendering anger and hopelessness in therapists (Gunderson 1984). Some clinicians thought not only that patients failed to respond to treatment, but that their problems were amplified by their involvement in therapy, simply because of the fundamental characteristics of their disorder (Harris 1994; Reiss 1996). Such opinions led to patients with personality disorder being considered as 'abusers' of mental health services (Warren 1996) and to personality disorder becoming a 'diagnosis of exclusion' from services (National Institute for Mental Health in England 2003).

Certainly, personality disorder was associated with longer, more costly treatment and higher attrition rates (Goldstein 1998; Blackburn 2000) and several studies indicated that its presence predicted poorer treatment outcome (Diger 1993; Hoglend 1993; Reich 1993). However, this research mostly derived from studies examining standard treatments for emotional disorders, rather than treatments specifically designed for personality

disorder. It could be argued that this is akin to offering aspirin to a person with a broken leg: the treatment addresses only one symptom rather than tackling the core problem.

Over the past 15 years, several new treatments have been designed to address personality disorder. There is a growing body of evidence suggesting that patients with personality disorder can respond to therapy. This is especially true for borderline personality disorder (Linehan 1991; Shea 1993; Davidson 1996; Wilberg 1999; Bateman 2000; Ryle 2000; Verheul 2003; Fonagy 2006). Some treatments are beginning to show promise with other 'types' of personality disorder such as antisocial personality disorder, although more research is required to build a useful evidence base (Davidson 2008a; Duggan 2008; Frisman 2009). Overviews of treatments are now more positive about the possibility of treating patients with personality disorders (Perry 1999; Leichsenring 2003; Bateman 2004).

These newer treatments range across the whole spectrum of theoretical models. In this article, treatment approaches have been divided broadly into two subsets, on the basis of their conceptualisation and the process of therapeutic change: through the building of new skills or through the development of insight. (It should be noted that this is an artificial divide since most treatments incorporate the development of both skills and insight.)

This article will focus on therapies using a skills-development approach. The goal of skills-based therapy is to increase the range of effective coping strategies to help patients identify and manage their cognitive, emotional and behavioural responses to events. Treatment aims to extinguish maladaptive thoughts and behaviours, and build new skills to help patients modulate and adaptively express underlying feelings. The treatment approaches included are primarily based on cognitive-behavioural therapy (CBT) such as those proposed by Beck and associates (Beck 2003) and Davidson (2007), and the more behaviourally oriented dialectical behaviour therapy (DBT; Linehan 1993a). These will be outlined in turn.

Cognitive-behavioural therapy

A number of different cognitive and cognitive-behavioural approaches for the treatment of personality disorder have been developed in recent years. Although there are some conceptual differences between them, the various approaches have much in common and all have their roots in the early cognitive therapies. To minimise confusion, CBT here refers to the full range of cognitive and cognitive-behavioural approaches.

Cognitive-behavioural therapy was first developed more than two decades ago for the treatment of depression and other emotional disorders (Ellis 1962; Beck 1967). In its early years, CBT was largely insight-oriented, primarily using introspective techniques to effect change. However, Beck, Ellis and others began to incorporate a range of behavioural techniques to strengthen the impact on dysfunctional controlling belief systems (schemas). Over time, the model has been applied to the treatment of a variety of clinical disorders including personality disorder. In the case of personality disorders, CBT therapists place a greater emphasis on developmental issues, the therapist-patient relationship and the need for a longer duration of treatment.

Cognitive-behavioural therapy concentrates on problem behaviours rather than the criteria identifying personality disorders. In CBT, personality disorders are simply seen as patterns of dysfunctional beliefs and behaviours that are rigid, overgeneralised, urgent and resistant to change. These dysfunctional beliefs and behaviours arise as a result of the operation of certain schemas or controlling beliefs that produce consistently biased judgements in the way patients view the world, and which lead to a tendency to make cognitive errors in certain types of situations. Each type of personality disorder is characterised by a distinct cognitive profile (a mixture of beliefs, attitudes and affect organised around a broad overview of the nature of the self and the world).

Cognitive-behavioural therapy uses a bio-social model hypothesising that the origin of personality disorder lies in the interaction of inherent temperament and the infant's emotional experience of its caregivers. It takes an evolutionary perspective, suggesting that personality traits are 'strategies' favoured by natural selection that have evolved as a result of their ability to sustain life and promote reproduction. However, our environment has changed over time and although some strategies may still be functional, others may be a 'poor fit' with our current context. Cognitive-behavioural therapists see strategies that are either

underdeveloped or overdeveloped and those which are a poor fit as constituting personality disorder.

Environmental influences also play a part in the development of personality disorder by increasing or decreasing the expression of these innate tendencies. When repeatedly reinforced in childhood, the tendencies can lead to specific belief systems (schemas). Once a core schema is established, patients will selectively attend to confirming evidence and will block any disconfirming evidence. Thus, core schemas will be continuously reinforced, becoming progressively more rigid and pervasive.

What happens in therapy?

Cognitive-behavioural therapy uses structured individual treatments that are problem-focused. It aims to temper the cognitive profile and so modify dysfunctional emotional and social responses to events. The goal is not to replace the dysfunctional schemas, but to modify beliefs and develop new ones, providing the patient with more effective strategies for coping with problematic situations (Box 1).

One of the cardinal principles in CBT is the formation of a therapeutic alliance with the patient. This is done to keep the patient motivated and engaged throughout therapy, by instilling a sense of trust and collaboration. The process begins at the start of therapy through a collaborative formulation of the patient's problems.

The formulation is a working hypothesis which links the long-standing problematic behaviours and interpersonal problems seen in personality disorder to a number of likely underlying core beliefs that have arisen as a result of childhood experiences. The formulation also assists in determining which strategies are likely to be the most effective in bringing about change.

BOX 1 Cognitive-behavioural therapy

- Cognitive techniques
 - Identify and evaluate dysfunctional thoughts
 - Uncover core schema/beliefs
 - Restructure, modify and/or reinterpret core schema/beliefs
- Behavioural techniques
 - Self-defeating behaviours are addressed
 - New adaptive skills are taught
 - Behavioural assignments are set to promote skills rehearsal and generalisation
- Imagery used to help restructure past experiences

Cognitive strategies

Cognitive strategies and techniques are used to alter maladaptive core beliefs about the self and the world. Various techniques are employed to help patients recognise maladaptive patterns of thinking and interpretation. The aim is to help patients identify and evaluate dysfunctional automatic thoughts and to elicit the ultimate meaning of events: to uncover the core schema at work.

Once the core schemas are accessible, there are three key ways to confront them. Schema restructuring helps patients to transform a maladaptive schema to an adaptive one. Schema modification does not produce new adaptive schemas, but modifies dysfunctional schemas and so reduces their impact and their effect on patients' responses. Finally, schema reinterpretation makes minor changes to existing schema but helps patients to reinterpret them and adapt their lifestyles to manage dysfunctionality.

Behavioural strategies

Behavioural strategies are used to promote a reduction in self-harm and other maladaptive behaviours, as well as to help the patient develop better ways of coping with their difficulties. The goals of behavioural techniques are threefold. The therapist may need to address patients' self-defeating behaviours. They may also need to teach/coach patients in new adaptive skills. Finally, behavioural assignments can be used as homework to help test out dysfunctional or newer adaptive cognitions.

Some common behavioural techniques employed include activity monitoring and scheduling, skills training (including behavioural rehearsal, relaxation training or social skills training) and exposure techniques for anxiety-based difficulties.

Other techniques

Imagery techniques to enable the patient to 'relive' past traumatic events are also used. These help patients to restructure experiences and consequently modify associated attitudes and beliefs.

Length of treatment

Cognitive-behavioural approaches to personality disorder are less intensive in terms of time than most insight-based treatments or DBT, often lasting about 12 months, and thus are economical to implement (Byford 2003).

Who does CBT work for?

Two randomised controlled trials have demonstrated that CBT is an effective treatment for patients with avoidant and Cluster B personality

disorder (Evans 1999; Emmelkamp 2006). Other trials have shown similar indications of promise in the treatment of borderline and mixed personality disorder but methodological difficulties and small treatment samples have limited potential outcomes (Tyrrer 2003; Davidson 2006; Weinberg 2006).

A recent pilot trial suggested that CBT may also be a promising treatment for men with antisocial personality (Davidson 2008b). However, more research needs to be undertaken to examine the value of CBT approaches with the different personality disorder types.

Training and implementation

Training is not yet available for CBT with personality disorder but several training routes provide expertise in generic CBT. All doctoral clinical psychology courses in the UK now teach CBT methodology so that clinical psychologists have a grounding in CBT techniques. Further training in CBT to certificate (10 days) and diploma level (18 days) is available from a variety of academic institutions, all of which are listed on the British Association for Behavioural and Cognitive Psychotherapies (BABCP) website (www.babcp.com). The BABCP has also published guidelines regarding the requisite training needed for a core professional to become an accredited CBT practitioner. This includes the completion of an accredited diploma-level course and a number of hours of supervised practice. Practitioners can continue their training to become eligible to supervise and train others.

Dialectical behaviour therapy

Developed in the USA by Marsha Linehan (1993a,b), DBT was designed for women in the community who self-harm. It is a long-term, structured, cognitive-behavioural treatment, which is intended to address the difficulties of borderline personality disorder.

Dialectical behaviour therapy is based on a biosocial theory of personality disorder in which biological factors and social learning influences interact reciprocally to bring about a dysfunction in the emotional regulation system. Biologically, patients are emotionally vulnerable. They are born with an autonomic nervous system which reacts excessively to relatively low levels of stress and which takes longer than normal to return to baseline.

Borderline personality disorder develops when such a child is brought up within an 'invalidating' environment, where the child's significant others negate and/or respond erratically (through denial, failure to respond or abuse) to the child's

experiences and responses. This lack of consistent acknowledgement of emotions prevents the child from learning to understand their feelings, and promotes distrust in their own responses.

Dialectical behaviour therapy is based on cognitive-behavioural principles but instead of focusing merely on changing the patients, DBT also includes acceptance strategies, often referred to as validation techniques. These are intended to communicate to the patient that they are acceptable as they are and that many of their thoughts, feelings and behaviours, however dysfunctional, make sense in some way.

The balance between acceptance and change strategies in DBT forms the fundamental 'dialectic' from which DBT derives its name. The dialectical method described in Buddhist philosophy is a means of seeking truth through the integration or synthesis of contradictory facts. Thus in DBT, therapists attempt to balance the requirement to accept patients for themselves, while recognising the need for them to change.

In describing the characteristics of borderline personality disorder, Linehan refers to a set of 'dialectical dilemmas'. These dilemmas are experienced by patients as dimensions of response to stressful events. Since each pole on a dimension is experienced as distressing, patients oscillate between opposing poles. This helps to explain the emotional lability and rapid changes in opinion and perspective often observed in such patients. The goal of therapy is to reduce this oscillation and help the patient manage their responses to events in a more integrated and adaptive way.

In terms of treatment, Linehan (1993a,b) focuses on personality disorder largely from a behavioural perspective: as a pattern of maladaptive behaviours. If the behaviours and underlying cognitions and emotions cease, so too does the diagnosis.

'In a nutshell, DBT is very simple. The therapist [...] blocks or extinguishes bad behaviors, drags good behaviors out of the patient, and figures out a way to make the good behaviors so reinforcing that the patient continues the good ones and stops the bad ones.' (Linehan 1993a).

What happens in therapy?

Dialectical behaviour therapy integrates individual psychotherapy with concurrent skills training and skills generalisation strategies, usually through telephone consultation. Thus, patients are expected to attend one individual session, and one 2-hour group skills session every week (Box 2). In addition, patients are encouraged to use a telephone consultation system, which allows them to access immediate (so-called *in vivo*) skills coaching when they are in crisis.

BOX 2 Dialectical behaviour therapy

Individual therapy

- Acceptance strategies (validation)
- Change strategies including:
 - identification of hierarchy of treatment targets
 - progress review on daily diary card
 - behavioural chain analysis for each difficulty encountered
 - solution analysis to find more effective strategies

Group work

- Training new adaptive skills for:
 - interpersonal effectiveness
 - emotion regulation
 - distress tolerance
 - core mindfulness

Telephone consultation

- '*In vivo*' skills coaching to promote skills rehearsal and generalisation

Individual therapy

Therapy commences with a motivational approach within individual therapy. In this phase the individual therapist must gain commitment from the patient to the therapy and the therapeutic procedures (individual, group work and skills coaching). This commitment includes an agreement to work on identified treatment targets. Patients are given a diary card listing their personal treatment targets on one side and the skills they will be learning on the other side. Patients complete the diary every day, charting their progress on targets and listing the skills they have practised. The diary forms the basis of the individual session, with the therapist identifying the most serious problems encountered during the week to use as the focus for the session.

Treatment targets In dialectical behaviour therapy, treatment targets are organised into hierarchical stages and, with few exceptions, addressed in strict order. This organisation prevents therapists from being distracted into addressing the crisis of the moment. Individual therapy focuses initially on 'first-stage targets' of decreasing suicidal and life-threatening behaviour and reducing 'therapy-interfering behaviours' (particularly non-adherence and premature withdrawal from therapy). Put simply, this means that DBT's first set of targets ensure that the patient remains alive and in therapy. Decreasing behaviours that have a detrimental effect on the quality of life form the remainder of the first-stage treatment targets.

Second- and third-stage targets include longer-term aspirations such as decreasing post-traumatic stress, increasing self-respect and achieving individual life goals.

Therapeutic strategies Individual DBT uses a number of different therapeutic strategies, but central to the treatment is the application of problem-solving strategies to elicit change. This entails the application of a behavioural chain analysis to each identified difficulty to determine what the problem is, what is causing it, what is interfering its resolution and what aids are available to help solve it. A behavioural chain analysis is a detailed outline of the events and situational factors leading up to and following the particular problem. The analysis pays close attention to the reciprocal interaction between the environment and the patient's cognitive, emotional and behavioural responses.

Solution analysis Having determined the exact nature of the problem, a solution analysis (to identify alternative behavioural solutions) is undertaken to help the patient find more effective coping strategies. The patient is then instructed and coached in the new strategies. Behavioural chain analyses will indicate skills deficits, problematic reinforcement contingencies, inhibitions resulting from fear and guilt, and faulty beliefs and assumptions. Thus, the instructional/coaching phase integrates skills training, contingency management, exposure strategies and cognitive modification.

Validation strategies Dialectical behaviour therapy is unusual because it pays as much attention to helping patients understand and accept themselves and their situation as it does in assisting them to change. Hence the application of problem-solving strategies is balanced by the application of validation strategies. There are two types of validation. In the first type the therapist highlights the wisdom in the patient's emotional, cognitive and behavioural responses. The second type of validation centres on the therapist's belief in the patient's ability to rebuild a life worth living, and building on the patient's strengths rather than weaknesses.

Patient-therapist relationship Essentially, individual therapy tailors the skills taught to the specific needs of the patient and assists in their application and generalisation to the patient's everyday life. However, it also provides the patient with a therapeutic attachment from which they can learn about attachments and relationships generally. For Linehan (1993a), the therapeutic alliance is the 'vehicle through which therapy occurs' as well as the therapy itself. A strong therapeutic relationship is also seen as essential because

the relationship with the therapist is often the key reinforcer for the patient striving to change their behaviour: 'If all else fails, the strength of the relationship will keep a patient alive during a crisis' (Linehan 1993a).

Group work

The group work component of DBT is the key method of increasing adaptive behavioural skills. Skills training comprises four modules covering interpersonal effectiveness, emotional regulation, distress tolerance and core mindfulness.

Interpersonal effectiveness This largely focuses on assertiveness skills. Patients are helped to understand their needs in relationships and to develop healthy and effective ways of dealing with others to get their needs met. This involves respecting themselves and others, communicating effectively, learning to say no, and repairing relationships.

Emotional regulation Skills in emotional regulation increase understanding of emotions. The group provides basic education about the nature and function of emotions, and how to not be overwhelmed by them.

Distress tolerance This module helps patients survive difficult times by teaching them to manage their lives even when they are feeling highly emotional. Patients are trained to soothe themselves in healthy ways and to help them manage their reactions to stressful events.

Core mindfulness Skills in core mindfulness are contemplative practices that originate from Zen Buddhism. The skills help patients control their concentration by directing attention to only one thing: the moment they are living in. Patients thus learn to control their minds, rather than letting their minds control them.

Telephone consultation

Unusually, patients in DBT are instructed to telephone their therapists for skills coaching if, outside of scheduled therapy time, they have urges to hurt themselves. The therapist does not undertake a full individual therapy session but simply talks the patient through the problem situation and coaches alternative strategies to self-harm or suicidal behaviours. In this way, skills are strengthened and generalised and the patient is kept safe.

Length of treatment

Dialectical behaviour therapy is a long-term intervention (1–2 years or more). The group work component takes about 12 months to complete

but patients are often recommended to repeat all or part of the programme. Individual therapy takes place before and during the skills component and often lasts long after the skills training has finished: until the diary card reflects an increased ability to manage the prescribed targets over a sustained period (3–6 months).

Who does DBT work for?

Two randomised controlled trials involving parasuicidal women in community settings have shown that DBT is more effective than treatment as usual in the treatment of borderline personality disorder. Over a 12-month period, participants receiving DBT were less likely to drop out of therapy and engaged in fewer and less severe parasuicidal acts when compared with the treatment-as-usual group. They also had fewer in-patient days, reported less anger, and had fewer and less severe psychiatric symptoms. These improvements continued during the 1-year follow-up (Linehan 1991, 1993c, 1994).

Various adaptations have been made to DBT to treat different patient populations: adolescents, in-patients, British and Dutch patients, women with substance dependency, women veterans, male and female forensic patients and women with eating disorders (Barley 1993; Springer 1996; Miller 1997; Linehan 1999; Swales 2000; Koons 2001; Low 2001; Telch 2001; Evershed 2003; Verheul 2003). Generally, results have been encouraging and support the value of DBT in treating patients with borderline personality disorder.

Training and implementation

Two-week DBT intensive training courses enable teams to develop competence in this approach. Training can be undertaken by individuals but this is on the assumption that no therapist would attempt to treat patients without support and supervision from a DBT consultation team. Trainers assume that attendees are experienced clinicians. There is one training provider in the UK and information about courses can be found online (www.dbt.uk.net; or www.behavioraltech.com for courses in the USA).

Critique of skills-based therapies

Skills-based therapies aim to extinguish problematic thoughts and behaviours, and to provide patients with a toolkit of adaptive skills to moderate and manage previously difficult situations. Primarily, therefore, skills-based therapies tend to focus on observable or accessible thoughts and behaviours as treatment targets and as outcome measures. These therapies pay far less attention to

causal mechanisms and processes. The underlying reasons for these thoughts, beliefs and behaviours are not seen as a key emphasis for treatment. Some writers have argued that this lack of emphasis could result in superficial change only: a focus on symptoms as opposed to the fundamental disorder (Roth 2005). It is essential therefore, that evaluations of skills-based therapies include a means of monitoring levels of patient distress or well-being as well as behaviour change.

Further problems with skills-based treatments relate to the therapeutic processes that rely heavily on the use of self-report and self-monitoring techniques (e.g. diaries). In these therapies there is an assumption that patients are able to access cognitions and emotions with minimal training, and that they can make changes to cognitions and behaviours with relative ease (Young 2003). Even if one rejects the existence of an ‘unconscious’, it is clear that people can be blind to their thoughts and feelings, and that many behaviours and cognitions in patients with personality disorder will be distorted, rigid and intractable, almost by definition.

A key criticism of CBT approaches in particular is that they emphasise techniques at the expense of ignoring the importance of the therapeutic relationship. In their defence, CBT practitioners are sensitive to the need to build an effective relationship if only because patients are unlikely to complete homework tasks unless they trust and respect the therapist (Dallos 2006).

Finally, further research is required into the efficacy of CBT for personality disorder (Young 2001). A recent meta-analysis for CBT with major psychiatric disorders (Lynch 2010) was pessimistic about its effects on disorders other than mood disorders. However, a review of the evidence for CBT and related therapies (including DBT) by Epp & Dobson (2010) was not so negative regarding its efficacy with borderline personality disorder.

One criticism of DBT is that the very structure which helps therapists maintain focus on key treatment targets (and avoid the distraction of the ‘unrelenting crises’ common in personality disorder) could in itself cause problems. Rigid adherence to the hierarchy of treatment targets could result in patients feeling ‘unvalidated’ by apparently uncaring therapists. Worse, it could lead to therapists ignoring very real and dangerous crises, leaving patients to fend for themselves. Dialectical behaviour therapy proponents would argue that such crises are likely to be seen as ‘therapy interfering’. As such, they would rise up the hierarchy allowing therapists to focus on them as a first-stage target.

MCQ answers

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Of perhaps more concern is the notion that patients will only be accepted into DBT once they have made a commitment to the treatment targets. Many prospective patients may find the idea of renouncing self-harm as a coping strategy (however maladaptive) to be unacceptable and will be unable to commit. They then may be prevented from gaining access to treatment while still engaging in potentially dangerous behaviour.

This article has examined DBT and CBT approaches as skills-based interventions. Both DBT and CBT have a limited but growing evidence base for use with personality disorder, but this does not mean that they are problem-free. All therapies have their weaknesses. Cognitive-behavioural therapy and DBT are no exception.

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MCQs

Select the single best option for each question stem

1 In CBT, personality disorders are seen primarily as patterns of rigid, over-generalised and imperative:

- a emotions
- b symptoms
- c emotions and beliefs
- d beliefs and behaviours
- e interpersonal attachments.

2 In CBT, the three key processes used to address maladaptive core schemas are:

- a replacement, challenge and reinterpretation
- b restructuring, modification and reinterpretation
- c restructuring, rekindling and acceptance
- d identification, modification and validation
- e modification, eradication and resolution.

3 Most of the research evidence regarding the efficacy of treatments for personality disorder focuses on:

- a borderline personality disorder
- b antisocial personality disorder
- c paranoid personality disorder
- d Cluster C personality disorder
- e narcissistic personality disorder.

4 According to DBT, two elements required for a child to develop borderline personality disorder are:

- a dysfunctional schemas and impulsive behaviour
- b urges to self-harm and a faulty belief system
- c impulsivity and poor assertiveness skills
- d sexual abuse and neglectful parents
- e emotional vulnerability and an invalidating environment.

5 The four modules of the skills component of DBT are:

- a core mindfulness, assertiveness, anger management and relaxation
- b social skills, risk management, urge control and core mindfulness
- c life skills, emotional regulation, anger management and anxiety management
- d imagery techniques, schema challenge, exposure techniques and activity monitoring
- e core mindfulness, interpersonal skills, emotion regulation and distress tolerance.

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Advances

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Sue Evershed

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